Assembly Bill No. 749

CHAPTER 6

An act to amend Section 9109 of the Commercial Code, to amend Sections 1871, 1871.4, 1872.83, 11721, 11734, 11737, 11770, 11783, 11784, 11785, 11786, 11787, 11820, 11822, and 11860 of, to add Section 11771.5 to, to add and repeal Section 11741 of, and to repeal Section 11823 of, the Insurance Code, and to amend Sections 62.6, 75, 77, 78, 90.5, 110, 123, 123.3, 123.5, 123.6, 124, 127, 129, 129.5, 133, 138, 138.1, 138.2, 138.4, 3501, 3550, 3551, 3722, 3762, 3820, 4061, 4062, 4062.9, 4064, 4067, 4453, 4455, 4600.3, 4600.5, 4628, 4644, 4646, 4651, 4658, 4659, 4702, 4703.5, 5275, 5305, 5307, 5310, 5311.5, 5401, 5405, 5500.3, 5502, 5814, 5814.5, and 6354.5 of, to amend the heading of Chapter 5 (commencing with Section 110) of Division 1 of, to add Sections 90.3, 127.5, 127.6, 139.47, 3201.7, 3201.9, 3822, 4600.1, 4600.2, 4600.35, 4603.4, 4903.5, 5307.2, 5307.21, and 6354.7 to, to add and repeal Sections 139.48 and 139.49 of, and to repeal Sections 139.05, 3552, and 4065 of the Labor Code, relating to workers' compensation.

[Approved by Governor February 15, 2002. Filed with Secretary of State February 19, 2002.]

LEGISLATIVE COUNSEL'S DIGEST

AB 749, Calderon. Workers' compensation: administration and benefits.

(1) Existing law provides for an annual assessment of employers by the Department of Industrial Relations for the purpose of funding increased investigation and prosecution of workers' compensation fraud by the Bureau of Fraudulent Claims of the Department of Insurance and by district attorneys. Existing law provides for the assessment of civil penalties for acts constituting workers' compensation fraud.

This bill would also authorize use of these funds for investigation and prosecution of an employer's willful failure to secure payment of workers' compensation. This bill would require the Bureau of State Audits to evaluate the effectiveness of the efforts of the Fraud Assessment Commission, the Bureau of Fraudulent Claims, the Department of Industrial Relations, and local law enforcement agencies in identifying, investigating, and prosecuting workers' compensation fraud and the willful failure to secure payment of workers' compensation. It would expand the membership of the Fraud Assessment Commission from 5 to 7 members by adding 2 representatives of organized labor. The bill would increase the civil

penalty amounts that could be imposed for workers' compensation fraud. These funds would be deposited in the Workers' Compensation Fraud Account in the Insurance Fund.

(2) Existing law requires workers' compensation insurers to maintain or provide occupational safety and health loss control consultation services certified by the Director of Industrial Relations.

This bill would eliminate the requirement that these services be certified by the director, would eliminate fees imposed on insurers for that certification, would accordingly eliminate the Loss Control Certification Fund in which these fees are deposited, would require an expansion of the scope of these services, and would make legislative findings in this regard. The bill would eliminate the requirement that each insurer submit an annual health and safety loss control plan to the director for identifying employers with the greatest workers' compensation losses and the most significant and preventable health and safety hazards.

The bill would require the Department of Industrial Relations to establish an insurance loss control services coordinator position to provide information to employers about the availability of these loss control consultation services, to be funded from the Workers' Occupational Safety and Health Education Fund that would be created by the bill. The bill would require the Commission on Health and Safety and Workers' Compensation to establish and maintain a worker occupational safety and health training and education program. The bill would require the director to levy and collect fees from workers' compensation insurers for purposes of the program, with the fees to be deposited in the Workers' Occupational Safety and Health Education Fund. Moneys in the fund could be expended for the above purposes upon appropriation by the Legislature.

(3) Existing law requires the Insurance Commissioner to designate a rating organization to assist him or her in developing, among other things, a classification system.

This bill would require the designated rating organization to develop and file with the Insurance Commissioner a weekly premium per employee for each classification used or proposed by the designated rating organization for use in determining the premium for an uninsured employer.

(4) Existing law provides for the Insurance Commissioner to approve rates for workers' compensation insurance.

This bill, notwithstanding any other provision of law, would authorize an insurer to increase rates on policies with inception dates prior to January 1, 2003, to reflect the changes in benefit levels enacted by this bill. It would also provide that the Insurance Commissioner would not

have the authority to disapprove a rate, discount, or credit established by an insurer for any policy issued to an employer for coverage of employees participating in a specified program established under a collective bargaining agreement.

(5) Existing law provides for a 6-member board of directors to administer the State Compensation Insurance Fund, with the Director of Industrial Relations serving as a nonvoting, ex officio member.

This bill would add the Speaker of the Assembly and the President pro Tempore of the Senate, or their designees, to the board as ex officio members.

(6) Existing law specifies the authority of the State Compensation Insurance Fund.

This bill would commission an independent study, with the assistance of an investment banking firm, to determine the feasibility of the State Compensation Insurance Fund issuing bonds or securities. The bill would require advertising of the fund to include a specified disclaimer.

(7) Existing law provides for a manager of the State Compensation Insurance Fund.

This bill would change the title of this officer to president.

(8) Existing law requires the rates of the State Compensation Insurance Fund to be fixed at a percentage of the payroll of any employer which, in the long run and on average, will produce a sufficient sum, when invested at $3^1/_2$% interest, to meet specified goals.

This bill would replace the $3^1/_2$% interest standard with a standard that the investment be made in a way so as to realize the maximum return consistent with safe and prudent management practices.

(9) Existing law makes certain conclusive presumptions regarding a child's or spouse's dependency on a deceased employee for support as it pertains to workers' compensation benefits.

This bill would make similar presumptions with respect to a deceased employee who has no person who qualifies as dependent on the support of the deceased employee.

(10) Existing law generally provides for settlement and commutation of workers' compensation benefits, but does not allow settlement or commutation of prospective vocational rehabilitation services except upon a specified finding by a workers' compensation judge.

This bill would additionally authorize an employee and a represented employee to settle the employee's right to prospective vocational rehabilitation services with a one-time payment under certain conditions.

(11) Existing law provides for the Department of Industrial Relations to be divided into at least 6 divisions, including the Division of Workers' Compensation, which is under the direction of an administrative

director. Existing law provides that the administrative director has various powers and duties with respect to the Workers' Compensation Appeals Board and workers' compensation administrative law judges who hear appeals of workers' compensation claims.

This bill would create the position of court administrator with respect to the workers' compensation adjudicatory process at the trial level, who would be appointed by the Governor with the advice and consent of the Senate. This bill would specify the court administrator's powers and duties. The bill would add various other provisions, including certain qualifications and ethics requirements for workers' compensation administrative law judges and other provisions relating to the operation of the workers' compensation courts.

(12) Existing law requires the administrative director to conduct audits of insurers, self-insured employers, and 3rd-party administrators to ensure that injured workers are promptly and accurately receiving the full measure of compensation they are entitled to receive.

This bill would require the administrative director to conduct a profile audit review of each audit subject at least once every 5 years and to conduct a full compliance audit on each audit subject that fails to meet or exceed the profile audit review performance standard established by the director. The bill would provide for the assessment of penalties on audit subjects that fail to meet established audit standards, and based on the results of these audits, the administrative director would be required to publish and make available on request a list ranking all insurers, self-insured employers, and 3rd-party administrators audited.

(13) Existing law requires that specified notices be provided to injured employees.

This bill would specify the contents of various notices that are required to be posted, given to, or mailed to an employee. The bill would provide for specified procedures to be used in notifying employees regarding benefits and required actions in pursuing a workers' compensation claim.

(14) Existing law provides that the Commission on Health and Safety and Workers' Compensation in the Department of Industrial Relations is to be funded by appropriations from the Workplace Health and Safety Revolving Fund, into which certain civil and administrative penalties are deposited.

This bill would instead provide for the deposit of these penalties in the Workers' Compensation Administration Revolving Fund, and would provide funding for the commission from this fund, upon appropriation by the Legislature.

(15) Existing law requires the Industrial Medical Council to, among other things, counsel and assist the administrative director and suggest standards for improving care furnished to injured employees.

This bill would require the administrative director, in consultation with the council and other specified entities, on or before July 1, 2003, to begin to conduct a study of medical treatment provided to workers who have sustained industrial injuries and illnesses. It would require the administrative director, on or before July 1, 2004, to make recommendations based on the study to the Legislature.

This bill, commencing July 1, 2004, until January 1, 2009, would require the administrative director to establish the Return-to-Work Program in order to promote the early and sustained return to work of the employee following a work-related injury or illness. The bill would create the Workers' Compensation Return-to-Work Fund, subject to appropriation by the Legislature, from which reimbursement would be made to employers meeting specified criteria relating to program participation. It would also require the administrative director to contract with an independent research organization to conduct a study and issue a report on the program, and to make this report available to the public and the Legislature on or before January 1, 2008.

(15.5) Existing law makes it a crime for any person to make false or fraudulent statements, or take certain other actions, with respect to any claim under the workers' compensation system.

This bill would also make it a crime to make or cause to be made any knowingly false or fraudulent material statement or representation in connection with claims and reimbursements under the Return-to-Work Program. The creation of these new crimes would impose a state-mandated local program.

(16) Existing law provides for the Director of Industrial Relations to issue and serve on any employer that has failed to secure the payment of workers' compensation a stop order prohibiting the use of employee labor, and to also issue and serve on the employer a penalty assessment order in the amount of $1,000 per employee employed, as specified.

This bill would authorize the director to assess a higher amount upon a determination that an employer has been uninsured for a period in excess of one week during the calendar year preceding the determination. The bill would enact other related changes with respect to these provisions. It would require the director to establish and maintain a program to encourage, facilitate, and educate employers to provide early and sustained return to work after occupational injury or illness.

This bill would also authorize the appeals board to provide for a summary hearing on the issue of compensability if a claim is settled by

the director by means of a compromise and release or stipulations with request for award.

(17) Existing law specifies the medical information about an injured employee that an insurer or a claim administrator may disclose to an employer, including the diagnosis of the injury if that diagnosis would affect the employer's premium.

This bill would permit disclosure to an employer of the mental or physical condition for which workers' compensation is claimed and the treatment provided for this condition.

(18) Existing law generally provides that the report of the qualified medical evaluator and the report of the treating physician with respect to a workers' compensation injury shall be the only admissible reports relative to making a determination with regard to an employer's workers' compensation liability. Existing law provides that once a worker has received a comprehensive medical-legal evaluation, the worker is not entitled to another evaluation if he or she later becomes represented by an attorney.

This bill would delete the limitation on obtaining another evaluation and would make various other changes to these and other related provisions.

(19) Existing law generally provides that the findings of the treating physician are presumed to be correct, unless rebutted, in cases where an additional comprehensive medical evaluation is obtained.

This bill would limit the operation of this presumption to situations involving the treatment of a worker by his or her personal physician or personal chiropractor, who was predesignated prior to the date of injury.

(20) Existing law requires injured employees to be provided with medical services, including prescription drugs.

This bill would require the use of generic drugs and would require the Administrative Director of the Division of Workers' Compensation to adopt by July 1, 2003, and revise no less frequently than biennially, an official pharmaceutical fee schedule. The bill would additionally require that the injured employee have access to a pharmacy within a reasonable distance from his or her residence. It would also provide that the administrative director has the sole authority to develop an outpatient surgery facility fee schedule for services not performed under contract.

(21) Existing law provides certain methods for determining workers' compensation benefits payable to a worker or his or her dependents for purposes of temporary disability, permanent total disability, permanent partial disability, and in case of death.

This bill would provide for increased temporary disability and permanent partial disability and death benefits for injuries or deaths occurring on or after January 1, 2003, with additional increases in

benefits phased in over several years. The bill would also revise the computation of the permanent disability benefit by increasing the number of weeks, as specified, for injuries occurring on or after January 1, 2004.

(22) Existing law requires that a disability indemnity payment made by any written instrument be immediately negotiable and payable in cash on demand.

This bill would provide that it is not a violation of this provision if a delay in the negotiation of a written instrument is caused solely by the application of state or federal banking laws or regulations.

(23) Existing law provides for the payment of workers' compensation death benefits to wholly dependent children, as defined, of a deceased employee-parent until the youngest child attains 18 years of age.

This bill would also provide these benefits to children who are physically or mentally incapacitated from earning until the death of these children.

(23.5) Existing law authorizes collective bargaining agreements between a private employer or groups of employers engaged in construction, construction maintenance, and related activities and a recognized or certified exclusive bargaining representative that establishes a dispute resolution process for workers' compensation instead of the hearing before the Workers' Compensation Appeals Board and its workers' compensation administrative law judges, or that provides for specified other alternative workers' compensation programs.

This bill would enact similar provisions with respect to employers in the aerospace and timber industries. By requiring certain information in connection with these provisions to be submitted by an employer under penalty of perjury, this bill would expand the definition of the crime of perjury, thereby imposing a state-mandated local program.

(24) Existing law requires certain disputes relating to workers' compensation to be submitted to arbitration, including certain disputes relating to permanent disability rating and vocational rehabilitation.

This bill would delete the requirement for the arbitration of these disputes.

(25) Existing law provides that medical and disability benefits may be claimed for up to one year from specific triggering events.

This bill would additionally establish timeframes whereby lien claimants must file liens against compensation.

(26) This bill would also require the Director of Industrial Relations to establish 8 additional workers' compensation administrative law judge positions and the same number of other associated positions.

(27) This bill would exempt a claim or right under workers' compensation from provisions relating to secured transactions.

(28) This bill would declare the intent of the Legislature relative to various matters.

(29) This bill would make various technical, nonsubstantive changes and other related changes.

(30) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares as follows:

(a) The prevention of workplace injuries and illnesses is an essential component of California's workers' compensation system.

(b) The provision of loss control services by insurers is an important tool in preventing injuries.

(c) The development and use of injury and illness prevention education programs also help reduce unnecessary injuries and illnesses.

(d) The certification program funded by the Loss Control Certification Fund is ineffective and should be redirected to more useful injury prevention programs.

(e) All existent funding available in, and all current fees used to maintain, the Loss Control Certification Fund should be used to establish the Loss Control Ombudsperson Fund and the Workers' Occupational Safety and Health Education Fund.

SEC. 2. Section 9109 of the Commercial Code is amended to read:

9109. (a) Except as otherwise provided in subdivisions (c) and (d), this division applies to each of the following:

(1) A transaction, regardless of its form, that creates a security interest in personal property or fixtures by contract.

(2) An agricultural lien.

(3) A sale of accounts, chattel paper, payment intangibles, or promissory notes.

(4) A consignment.

(5) A security interest arising under Section 2401 or 2505, or under subdivision (3) of Section 2711, or subdivision (5) of Section 10508, as provided in Section 9110.

(6) A security interest arising under Section 4210 or 5118.

(b) The application of this division to a security interest in a secured obligation is not affected by the fact that the obligation is itself secured by a transaction or interest to which this division does not apply.

(c) This division does not apply to the extent that any of the following conditions is satisfied:

(1) A statute, regulation, or treaty of the United States preempts this division.

(2) Another statute of this state expressly governs the creation, perfection, priority, or enforcement of a security interest created by this state or a governmental unit of this state. These statutes include statutes that provide for pledges, liens, or security interests to secure bonds or other obligations (including, without limitation, leases) of this state or a governmental unit, whether the statute is of general application like Sections 5450 and 5451 of the Government Code, or is specific to particular types of obligations of this state or of governmental units or to particular governmental units.

(3) A statute of another state, a foreign country, or a governmental unit of another state or a foreign country, other than a statute generally applicable to security interests, expressly governs creation, perfection, priority, or enforcement of a security interest created by the state, country, or governmental unit.

(4) The rights of a transferee beneficiary or nominated person under a letter of credit are independent and superior under Section 5114.

(d) This division does not apply to any of the following:

(1) A landlord’s lien, other than an agricultural lien.

(2) A lien, other than an agricultural lien, given by statute or other rule of law for services or materials, but Section 9333 applies with respect to priority of the lien.

(3) An assignment of a claim for wages, salary, or other compensation of an employee.

(4) A sale of accounts, chattel paper, payment intangibles, or promissory notes as part of a sale of the business out of which they arose.

(5) An assignment of accounts, chattel paper, payment intangibles, or promissory notes which is for the purpose of collection only.

(6) An assignment of a right to payment under a contract to an assignee that is also obligated to perform under the contract.

(7) An assignment of a single account, payment intangible, or promissory note to an assignee in full or partial satisfaction of a preexisting indebtedness.

(8) Any loan made by an insurance company pursuant to the provisions of a policy or contract issued by it and upon the sole security of the policy or contract.

(9) An assignment of a right represented by a judgment, other than a judgment taken on a right to payment that was collateral.

(10) A right of recoupment or setoff, provided that both of the following sections apply:

(A) Section 9340 applies with respect to the effectiveness of rights of recoupment or setoff against deposit accounts.

(B) Section 9404 applies with respect to defenses or claims of an account debtor.

(11) The creation or transfer of an interest in or lien on real property, including a lease or rents thereunder, except to the extent that provision is made for each of the following:

(A) Liens on real property in Sections 9203 and 9308.

(B) Fixtures in Section 9334.

(C) Fixture filings in Sections 9501, 9502, 9512, 9516, and 9519.

(D) Security agreements covering personal and real property in Section 9604.

(12) An assignment of a claim arising in tort, other than a commercial tort claim, but Sections 9315 and 9322 apply with respect to proceeds and priorities in proceeds.

(13) An assignment of a deposit account in a consumer transaction, but Sections 9315 and 9322 apply with respect to proceeds and priorities in proceeds.

(14) Any security interest created by the assignment of the benefits of any public construction contract under the Improvement Act of 1911 (Division 7 (commencing with Section 5000), Streets and Highways Code).

(15) Transition property, as defined in Section 840 of the Public Utilities Code, except to the extent that the provisions of this division are referred to in Article 5.5 (commencing with Section 840) of Chapter 4 of Part 1 of Division 1 of the Public Utilities Code.

(16) A claim or right of an employee or employee's dependents to receive workers' compensation under Division 1 (commencing with Section 50) or Division 4 (commencing with Section 3200) of the Labor Code.

SEC. 2.5. Section 1871 of the Insurance Code is amended to read:

1871. The Legislature finds and declares as follows:

(a) The business of insurance involves many transactions that have the potential for abuse and illegal activities. There are numerous law enforcement agencies on the state and local levels charged with the responsibility for investigating and prosecuting fraudulent activity. This chapter is intended to permit the full utilization of the expertise of the commissioner and the department so that they may more effectively investigate and discover insurance frauds, halt fraudulent activities, and

assist and receive assistance from federal, state, local, and administrative law enforcement agencies in the prosecution of persons who are parties in insurance frauds.

(b) Insurance fraud is a particular problem for automobile policyholders; fraudulent activities account for 15 to 20 percent of all auto insurance payments. Automobile insurance fraud is the biggest and fastest growing segment of insurance fraud and contributes substantially to the high cost of automobile insurance with particular significance in urban areas.

(c) Prevention of automobile insurance fraud will significantly reduce the incidence of severity and automobile insurance claim payments and will therefore produce a commensurate reduction in automobile insurance premiums.

(d) Workers' compensation fraud harms employers by contributing to the increasingly high cost of workers' compensation insurance and self-insurance and harms employees by undermining the perceived legitimacy of all workers' compensation claims.

(e) Prevention of workers' compensation insurance fraud may reduce the number of workers' compensation claims and claim payments thereby producing a commensurate reduction in workers' compensation costs. Prevention of workers' compensation insurance fraud will assist in restoring confidence and faith in the workers' compensation system, and will facilitate expedient and full compensation for employees injured at the workplace.

(f) The actions of employers who fraudulently underreport payroll or fail to report payroll for all employees to their insurance company in order to pay a lower workers' compensation premium result in significant additional premium costs and an unfair burden to honest employers and their employees.

(g) The actions of employers who fraudulently fail to secure the payment of workers' compensation as required by Section 3700 of the Labor Code harm employees, cause unfair competition for honest employers, and increase costs to taxpayers.

(h) Health insurance fraud is a particular problem for health insurance policyholders. Although there are no precise figures, it is believed that fraudulent activities account for billions of dollars annually in added health care costs nationally. Health care fraud causes losses in premium dollars and increases health care costs unnecessarily.

SEC. 2.7. Section 1871.4 of the Insurance Code is amended to read:

1871.4. (a) It is unlawful to do any of the following:

(1) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of

obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.

(2) Present or cause to be presented any knowingly false or fraudulent written or oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.

(3) Knowingly assist, abet, conspire with, or solicit any person in an unlawful act under this section.

(4) Make or cause to be made any knowingly false or fraudulent statements with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.

For the purposes of this subdivision, ''statement'' includes, but is not limited to, any notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-ray, test results, medical-legal expense as defined in Section 4620 of the Labor Code, other evidence of loss, injury, or expense, or payment.

(5) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any of the benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.

(6) Make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of discouraging an employer from claiming any of the benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.

(b) Every person who violates subdivision (a) shall be punished by imprisonment in county jail for one year, or in the state prison, for two, three, or five years, or by a fine not exceeding fifty thousand dollars ($50,000) or double the value of the fraud, whichever is greater, or by both imprisonment and fine. Restitution shall be ordered, including restitution for any medical evaluation or treatment services obtained or provided. The court shall determine the amount of restitution and the person or persons to whom the restitution shall be paid.

(c) Any person who violates subdivision (a) and who has a prior felony conviction of that subdivision, of former Section 556, of former Section 1871.1, or of Section 548 or 550 of the Penal Code, shall receive a two-year enhancement for each prior conviction in addition to the sentence provided in subdivision (b).

The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury

trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

(d) This section shall not be construed to preclude the applicability of any other provision of criminal law that applies or may apply to any transaction.

SEC. 3. Section 1872.83 of the Insurance Code is amended to read:

1872.83. (a) The commissioner shall ensure that the Bureau of Fraudulent Claims aggressively pursues all reported incidents of probable workers' compensation fraud, as defined in Sections 11760 and 11880, in subdivision (a) of Section 1871.4, and in Section 549 of the Penal Code, and forwards to the appropriate disciplinary body the names, along with all supporting evidence, of any individuals licensed under the Business and Professions Code who are suspected of actively engaging in fraudulent activity. The Bureau of Fraudulent Claims shall forward to the Insurance Commissioner or the Director of Industrial Relations, as appropriate, the name, along with all supporting evidence, of any insurer, as defined in subdivision (c) of Section 1877.1, suspected of actively engaging in the fraudulent denial of claims.

(b) To fund increased investigation and prosecution of workers' compensation fraud, and of willful failure to secure payment of workers' compensation, in violation of Section 3700.5 of the Labor Code, there shall be an annual assessment as follows:

(1) The aggregate amount of the assessment shall be determined by the Fraud Assessment Commission, which is hereby established. The commission shall be composed of seven members consisting of two representatives of organized labor, two representatives of self-insured employers, one representative of insured employers, one representative of workers' compensation insurers, and the President of the State Compensation Insurance Fund, or his or her designee.

The Governor shall appoint members representing organized labor, self-insured employers, insured employers, and insurers. The term of office of members of the commission shall be four years, and a member shall hold office until the appointment of a successor. The President of the State Compensation Insurance Fund shall be an ex officio, voting member of the commission. Members of the commission shall receive one hundred dollars ($100) for each day of actual attendance at commission meetings and other official commission business, and shall also receive their actual and necessary traveling expenses incurred in the performance of commission duties. Payment of per diem and travel expenses shall be made from the Workers' Compensation Fraud Account in the Insurance Fund, established in paragraph (4), upon appropriation by the Legislature.

(2) In determining the aggregate amount of the assessment, the Fraud Assessment Commission shall consider the advice and recommendations of the Bureau of Fraudulent Claims and the commissioner.

(3) The aggregate amount of the assessment shall be collected by the Director of Industrial Relations pursuant to Section 62.6 of the Labor Code. The Fraud Assessment Commission shall annually advise the Director of Industrial Relations, not later than March 15, of the aggregate amount to be assessed for the next fiscal year.

(4) The amount collected, together with the fines collected for violations of the unlawful acts specified in Sections 1871.4, 11760, and 11880, Section 3700.5 of the Labor Code, and Section 549 of the Penal Code, shall be deposited in the Workers' Compensation Fraud Account in the Insurance Fund, which is hereby created, and may be used, upon appropriation by the Legislature, only for enhanced investigation and prosecution of workers' compensation fraud and of willful failure to secure payment of workers' compensation as provided in this section.

(c) For each fiscal year, the total amount of revenues derived from the assessment pursuant to subdivision (b) shall, together with amounts collected pursuant to fines imposed for unlawful acts described in Sections 1871.4, 11760, and 11880, Section 3700.5 of the Labor Code, and Section 549 of the Penal Code, not be less than three million dollars ($3,000,000). Any funds appropriated by the Legislature pursuant to subdivision (b) that are not expended in the fiscal year for which they have been appropriated, and that have not been allocated under subdivision (f), shall be applied to satisfy for the immediately following fiscal year the minimum total amount required by this subdivision. In no case may that money be transferred to the General Fund.

(d) After incidental expenses, at least 40 percent of the funds to be used for the purposes of this section shall be provided to the Bureau of Fraudulent Claims of the Department of Insurance for enhanced investigative efforts, and at least 40 percent of the funds shall be distributed to district attorneys, pursuant to a determination by the commissioner with the advice and consent of the bureau and the Fraud Assessment Commission, as to the most effective distribution of moneys for purposes of the investigation and prosecution of workers' compensation fraud cases and cases relating to the willful failure to secure the payment of workers' compensation. Each district attorney seeking a portion of the funds shall submit to the commissioner an application setting forth in detail the proposed use of any funds provided. A district attorney receiving funds pursuant to this subdivision shall submit an annual report to the commissioner with respect to the success of his or her efforts. Upon receipt, the commissioner shall provide copies

to the bureau and the Fraud Assessment Commission of any application, annual report, or other documents with respect to the allocation of money pursuant to this subdivision. Both the application for moneys and the distribution of moneys shall be public documents. Information submitted to the commissioner pursuant to this section concerning criminal investigations, whether active or inactive, shall be confidential.

(e) If a district attorney is determined by the commissioner to be unable or unwilling to investigate and prosecute workers' compensation fraud claims or claims relating to the willful failure to secure the payment of workers' compensation, the commissioner shall discontinue distribution of funds allocated for that county and may redistribute those funds according to this subdivision.

(1) The commissioner shall promptly determine whether any other county could assert jurisdiction to prosecute the fraud claims or claims relating to the willful failure to secure the payment of workers' compensation that would have been brought in the nonparticipating county, and if so, the commissioner may award funds to conduct the prosecutions redirected pursuant to this subdivision. These funds may be in addition to any other fraud prosecution funds or claims relating to the willful failure to secure the payment of workers' compensation prosecution otherwise awarded under this section. Any district attorney receiving funds pursuant to this subdivision shall first agree that the funds shall be used solely for investigating and prosecuting those cases of workers' compensation fraud or claims relating to the willful failure to secure the payment of workers' compensation that are redirected pursuant to this subdivision and submit an annual report to the commissioner with respect to the success of the district attorney's efforts. The commissioner shall keep the Fraud Assessment Commission fully informed of all reallocations of funds under this paragraph.

(2) If the commissioner determines that no district attorney is willing or able to investigate and prosecute the workers' compensation fraud claims or claims relating to the willful failure to secure the payment of workers' compensation arising in the nonparticipating county, the commissioner, with the advice and consent of the Fraud Assessment Commission, may award to the Attorney General some or all of the funds previously awarded to the nonparticipating county. Before the commissioner may award any funds, the Attorney General shall submit to the commissioner an application setting forth in detail his or her proposed use of any funds provided and agreeing that any funds awarded shall be used solely for investigating and prosecuting those cases of workers' compensation fraud or claims relating to the willful failure to secure the payment of workers' compensation that are redirected

pursuant to this subdivision. The Attorney General shall submit an annual report to the commissioner with respect to the success of the fraud prosecution efforts of his or her office.

(3) Neither the Attorney General nor any district attorney shall be required to relinquish control of any investigation or prosecution undertaken pursuant to this subdivision unless the commissioner determines that satisfactory progress is no longer being made on the case or the case has been abandoned.

(4) A county that has become a nonparticipating county due to the inability or unwillingness of its district attorney to investigate and prosecute workers' compensation fraud or the willful failure to secure the payment of workers' compensation shall not become eligible to receive funding under this section until it has submitted a new application that meets the requirements of subdivision (d) and the applicable regulations.

(f) If in any fiscal year the Bureau of Fraudulent Claims does not use all of the funds made available to it under subdivision (d), any remaining funds may be distributed to district attorneys pursuant to a determination by the commissioner in accordance with the same procedures set forth in subdivision (d).

(g) The commissioner shall adopt rules and regulations to implement this section in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Included in the rules and regulations shall be the criteria for redistributing funds to district attorneys and the Attorney General. The adoption of the rules and regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare.

(h) The department shall report on an annual basis to the Legislature and the Fraud Assessment Commission on the activities of the Bureau of Fraudulent Claims and district attorneys supported by the funds provided by this section.

The annual report shall include, but is not limited to, all of the following information for the department and each district attorney's office:

(1) All allocations, distributions, and expenditures of funds.

(2) The number of search warrants issued.

(3) The number of arrests and prosecutions, and the aggregate number of parties involved in each.

(4) The number of convictions and the names of all convicted fraud perpetrators.

(5) The estimated value of all assets frozen, penalties assessed, and restitutions made for each conviction.

(6) Any additional items necessary to fully inform the Fraud Assessment Commission and the Legislature of the fraud-fighting efforts financed through this section.

(i) In order to meet the requirements of subdivision (g), the department shall submit a biannual information request to those district attorneys who have applied for and received funding through the annual assessment process under this section.

(j) Assessments levied or collected to fight workers' compensation fraud and insurance fraud are not taxes. Those funds are entrusted to the state to fight fraud and the willful failure to secure the payment of workers' compensation by funding state and local investigation and prosecution efforts. Accordingly, any funds resulting from assessments, fees, penalties, fines, restitution, or recovery of costs of investigation and prosecution deposited in the Insurance Fund shall not be deemed ''unexpended'' funds for any purpose and, if remaining in that account at the end of any fiscal year, shall be applied as provided in subdivision (f) and to offset or augment subsequent years' program funding.

(k) The Bureau of State Audits shall evaluate the effectiveness of the efforts of the Fraud Assessment Commission, the Bureau of Fraudulent Claims, the Department of Insurance, and the Department of Industrial Relations, as well as local law enforcement agencies, including district attorneys, in identifying, investigating, and prosecuting workers' compensation fraud and the willful failure to secure payment of workers' compensation. The report shall specifically identify areas of deficiencies. Included in this report shall be recommendations on whether the current program provides the appropriate levels of accountability for those responsible for the allocation and expenditure of funds raised from the assessment provided in this section. The Bureau of State Audits shall submit a report to the Chairperson of the Senate Committee on Labor and Industrial Relations and the Chairperson of the Assembly Committee on Insurance on or before May 1, 2004.

SEC. 4. Section 11721 of the Insurance Code is amended to read:

11721. An insurer desiring to write workers' compensation insurance shall maintain or provide occupational safety and health loss control consultation services pursuant to Section 6354.5 of the Labor Code.

SEC. 5. Section 11734 of the Insurance Code is amended to read:

11734. (a) Every workers' compensation insurer shall adhere to a uniform experience rating plan filed with the commissioner by a rating organization designated by the commissioner and subject to his or her disapproval.

(b) The commissioner shall designate a rating organization to assist him or her in gathering, compiling, and reporting relevant statistical information, and to develop a classification system. An insurer may develop its own classification system upon which a rate may be made or adopt the classification system developed by the designated rating organization; provided, however, that any classification system developed by an insurer must be filed with the commissioner 30 days prior to its use. The commissioner shall disapprove a classification system filed by an insurer pursuant to this section if the insurer fails to demonstrate that the data thereby produced can be reported consistent with the uniform statistical plan or the classification system developed by the rating organization. Every workers' compensation insurer shall record and report its workers' compensation experience to the designated rating organization as set forth in the uniform statistical plan approved by the commissioner.

(c) The designated rating organization shall develop and file manual rules, subject to the approval of the commissioner, reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan, and any classification systems that may be in effect. Every workers' compensation insurer shall adhere to the approved manual rules and experience rating plan in writing and reporting its business. No insurer shall agree with any other insurer or with a rating organization to adhere to manual rules that are not reasonably related to the recording and reporting of data pursuant to the uniform statistical plan or classification system developed by the rating organization.

(d) The designated rating organization shall also develop and file with the commissioner a weekly premium per employee for each classification used or proposed for use by that organization. The weekly premium shall be developed by applying the proposed rate for each classification to the state average weekly wage. For the purpose of this section, ''state average weekly wage'' means the average weekly wage paid by employers to employees covered by unemployment insurance as reported by the United States Department of Labor for California for the 12 months ending March 31 of the calendar year preceding the year in which the injury occurred.

SEC. 6. Section 11737 of the Insurance Code is amended to read:

11737. (a) The commissioner may disapprove a rate if the insurer fails to comply with the filing requirements under Section 11735.

(b) If the commissioner believes that rates may violate any of the requirements of this article, he or she shall call a hearing prior to any disapproval. The commissioner shall disapprove a rate if he or she finds that the rate would, if continued in use, tend to impair or threaten the

solvency of an insurer or tend to create a monopoly in the market pursuant to Section 11732.

(c) Every insurer or rating organization shall provide within this state reasonable means whereby any person aggrieved by the application of its filings may be heard on written request to review the manner in which the rating system has been applied in connection with the insurance afforded or offered. If the insurer or rating organization fails to grant or reject the request within 30 days, the applicant may proceed in the same manner as if the application had been rejected. Any party affected by the action of the insurer or rating organization on the request may, within 30 days after written notice of the action, appeal to the commissioner who, after a hearing held within 60 days from the date on which the party requests the appeal, or longer upon agreement of the parties and not less than 10 days' written notice to the appellant and to the insurer or rating organization, may affirm, modify, or reverse that action. If the commissioner has information on the subject from which the appeal is taken and believes that a reasonable basis for the appeal does not exist or that the appeal is not made in good faith, the commissioner may deny the appeal without a hearing. The denial shall be in writing and shall set forth the basis for the denial and shall be served on all parties.

(d) If the commissioner disapproves a rate, the commissioner shall issue an order specifying in what respects it fails to meet the requirements of this article and stating when within a reasonable period thereafter that rate shall be discontinued for any policy issued or renewed after a date specified in the order. The order shall be issued within 30 days after the close of the hearing or within any reasonable time extension as the commissioner may fix. The order may include a provision for premium adjustment for the period after the effective date of the order for policies in effect on that date.

(e) Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates or other act, the commissioner shall on request of the insurer specify interim rates for the insurer that are adequate to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by him or her. When new rates become legally effective, the commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds of less than ten dollars ($10) per policyholder shall not be required.

(f) Notwithstanding any other provision of law, an insurer may increase rates on policies with inception dates prior to January 1, 2003, in an amount no greater than the pure premium rate increase approved by the commissioner reflecting the cost of the change in benefit levels authorized by the act adding this subdivision.

SEC. 6.5. Section 11741 is added to the Insurance Code, to read:

11741. (a) Notwithstanding any other provision of this code or the Labor Code, the commissioner shall not have the authority to disapprove a rate, discount, or credit established by any insurer for any policy issued to an employer for coverage of employees participating in a program established in accordance with Section 3201.5 of the Labor Code.

(b) The Department of Insurance shall report to the Legislature on or before December 31, 2005, regarding the adequacy of rates charged by insurers under subdivision (a) between January 1, 2003, to December 31, 2004, inclusive. Insurers shall supply the Department of Insurance with any and all necessary requested information in order for the Department of Insurance to prepare and provide the report set forth in this section.

(c) This section shall not apply to policies issued or renewed on or after January 1, 2007.

(d) This section shall remain in effect only until January 1, 2007, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2007, deletes or extends that date.

SEC. 7. Section 11770 of the Insurance Code is amended to read:

11770. The State Compensation Insurance Fund is continued in existence, to be administered by its board of directors for the purpose of transacting workers' compensation insurance, and insurance against the expense of defending any suit for serious and willful misconduct, against an employer or his or her agent, and insurance to employees and other persons of the compensation fixed by the workers' compensation laws for employees and their dependents. Any appropriation made therefrom or thereto before the effective date of this code shall continue to be available for the purposes for which it was made.

The board of directors of the State Compensation Insurance Fund is composed of five members, one of whom shall be from organized labor, appointed by the Governor. The Governor shall appoint the chairperson who shall serve at the pleasure of the Governor. The Director of Industrial Relations, the Speaker of the Assembly, and the President pro Tempore of the Senate, or their designees, shall be ex officio, nonvoting members of the board, and shall not be counted as members of the board for quorum purposes or any other purpose.

The term of office of the members of the board, other than that of the director, the Speaker of the Assembly, and the President pro Tempore of the Senate, shall be five years and they shall hold office until the appointment and qualification of their successors. The term of office of the first additional member appointed pursuant to amendment of this section effective January 1, 1990, shall expire on January 15, 1995. Commencing January 15, 1991, the terms of office of other members shall be extended to five years as each four-year term expires, so that one

member's term of office expires January 15 of each year. Each member shall receive his or her actual and necessary traveling expenses incurred in the performance of his or her duty as a member and, with the exception of the ex officio members, one hundred dollars ($100) for each day of his or her actual attendance at meetings of the board. In order to qualify for membership on the board, each member other than the ex officio members shall have been a policyholder or the employee or member of a policyholder in the State Compensation Insurance Fund for one year immediately preceding the appointment, and must continue in this status during the period of his or her membership.

SEC. 8. Section 11771.5 is added to the Insurance Code, to read:

11771.5. Any advertising of the State Compensation Insurance Fund shall include the following disclaimer: ''The State Compensation Insurance Fund is not a branch of the State of California.''

SEC. 9. Section 11783 of the Insurance Code is amended to read:

11783. The State Compensation Insurance Fund may:

(a) Sue and be sued in all actions arising out of any act or omission in connection with its business or affairs.

(b) Enter into any contracts or obligations relating to the State Compensation Insurance Fund which are authorized or permitted by law.

(c) Invest and reinvest the moneys belonging to the fund as provided by this chapter.

(d) Conduct all business and affairs and perform all acts relating to the fund whether or not specifically designated in this chapter.

(e) Commission an independent study, with the assistance of an investment banking firm, to determine the feasibility of the State Compensation Insurance Fund issuing bonds or securities. The study may include, among other things, the purpose for issuing bonds and any potential adverse consequences that may arise from that issuance.

SEC. 10. Section 11784 of the Insurance Code is amended to read:

11784. In conducting the business and affairs of the fund, the president of the fund may do any of the following:

(a) Enter into contracts of workers' compensation insurance.

(b) Sell annuities covering compensation benefits.

(c) Decline to insure any risk in which the minimum requirements of the industrial accident prevention authorities with regard to construction, equipment, and operation are not complied with, or which is beyond the safe carrying of the fund. Otherwise, he or she shall not refuse to insure any workers' compensation risk under state law, tendered with the premium therefor.

(d) Reinsure any risk or any part thereof.

(e) Cause to be inspected and audited the payrolls of employers applying to the fund for insurance.

(f) Make rules for the settlement of claims against the fund and determine to whom and through whom the payments of compensation are to be made.

(g) Contract with physicians and surgeons, and hospitals, for medical and surgical treatment and the care and nursing of injured persons entitled to benefits from the fund.

SEC. 11. Section 11785 of the Insurance Code is amended to read:

11785. The board of directors shall appoint a president of the fund and fix his or her salary. The president shall manage and conduct the business and affairs of the fund under the general direction and subject to the approval of the board of directors, and shall perform other duties as the board of directors prescribes.

SEC. 12. Section 11786 of the Insurance Code is amended to read:

11786. Before entering on the duties of his or her office, the president shall qualify by giving an official bond approved by the board of directors in the sum of fifty thousand dollars ($50,000) and by taking and subscribing to an official oath. The approval of the board shall be by written endorsement on the bond. The bond shall be filed in the office of the Secretary of State.

SEC. 13. Section 11787 of the Insurance Code is amended to read:

11787. The board of directors may delegate to the president of the fund, under those rules and regulations and subject to those conditions as it from time to time prescribes, any power, function, or duty conferred by law on the board of directors in connection with the fund or in connection with the administration, management, and conduct of the business and affairs of the fund. The president may exercise those powers and functions and perform those duties with the same force and effect as the board of directors, but subject to its approval.

SEC. 14. Section 11820 of the Insurance Code is amended to read:

11820. Subject to the provisions of Article 2 (commencing with Section 11730) of Chapter 3, the board of directors shall establish the rates to be charged by the State Compensation Insurance Fund for insurance issued by it. These rates shall be fixed with due regard to the physical hazards of each industry, occupation, or employment.

SEC. 15. Section 11822 of the Insurance Code is amended to read:

11822. The rates fixed by the board of directors shall be that percentage of the payroll of any employer which, in the long run and on the average, will produce a sufficient sum, when invested in a way as to realize the maximum return consistent with safe and prudent management practices:

(a) To carry all claims to maturity. The rates shall be based upon the ‘‘reserve’’ and not upon the ‘‘assessment’’ plan.

(b) To meet the reasonable expenses of conducting the business of the fund.

(c) To produce a reasonable surplus to cover the catastrophe hazard.

SEC. 16. Section 11823 of the Insurance Code is repealed.

SEC. 17. Section 11860 of the Insurance Code is amended to read:

11860. Each quarter the president of the State Compensation Insurance Fund shall make a report to the Governor of the business done by the State Compensation Insurance Fund during the previous quarter and a statement of the fund's resources and liabilities at the close of that previous quarter. The State Compensation Insurance Fund shall, at its own expense, hire a recognized firm of certified public accountants to audit annually the books and records of the State Compensation Insurance Fund and cause an abstract summary thereof to be published one or more times in at least two newspapers of general circulation in the state. The president of the fund shall additionally provide the commissioner with all reports required by law to be made to him or her by other insurers.

SEC. 18. Section 62.6 of the Labor Code is amended to read:

62.6. (a) The director shall levy and collect assessments from employers in accordance with subdivision (b), as necessary, to collect the aggregate amount determined by the Fraud Assessment Commission pursuant to Section 1872.83 of the Insurance Code. Revenues derived from the assessments shall be deposited in the Workers' Compensation Fraud Account in the Insurance Fund and shall only be expended, upon appropriation by the Legislature, for the investigation and prosecution of workers' compensation fraud and the willful failure to secure payment of workers' compensation, as prescribed by Section 1872.83 of the Insurance Code.

(b) Assessments shall be levied by the director upon all employers as defined in Section 3300. The total amount of the assessment shall be allocated between self-insured employers and insured employers in proportion to payroll respectively paid in the most recent year for which payroll information is available. The director shall promulgate reasonable rules and regulations governing the manner of collection of the assessment. The rules and regulations shall require the assessment to be paid by self-insurers to be expressed as a percentage of indemnity paid during the most recent year for which information is available, and the assessment to be paid by insured employers to be expressed as a percentage of premium. In no event shall the assessment paid by insured employers be considered a premium for computation of a gross premium tax or agents' commission.

SEC. 19. Section 75 of the Labor Code is amended to read:

75. (a) There is in the department the Commission on Health and Safety and Workers' Compensation. The commission shall be composed of eight voting members. Four voting members shall represent organized labor, and four voting members shall represent employers. Not more than one employer member shall represent public agencies. Two of the employer and two of the labor members shall be appointed by the Governor. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint one employer and one labor representative. The public employer representative shall be appointed by the Governor. No action of the commission shall be valid unless agreed to by a majority of the membership and by not less than two members representing organized labor and two members representing employers.

(b) The commission shall select one of the members representing organized labor to chair the commission during the 1994 calendar year, and thereafter the commission shall alternatively select an employer and organized labor representative to chair the commission for one-year terms.

(c) The initial terms of the members of the commission shall be four years, and they shall hold office until the appointment of a successor. However, the initial terms of one employer and one labor member appointed by the Governor shall expire on December 31, 1995; the initial terms of the members appointed by the Senate Committee on Rules shall expire December 31, 1996; the initial terms of the members appointed by the Speaker of the Assembly shall expire on December 31, 1997; and the initial term of one employer and one labor member appointed by the Governor shall expire on December 31, 1998. Any vacancy shall be filled by appointment to the unexpired term.

(d) The commission shall meet every other month and upon the call of the chair. Meetings shall be open to the public. Members of the commission shall receive one hundred dollars ($100) for each day of their actual attendance at meetings of the commission and other official business of the commission and shall also receive their actual and necessary traveling expenses incurred in the performance of their duty as a member. Payment of per diem and traveling expenses shall be made from the Workers' Compensation Administration Revolving Fund, when appropriated by the Legislature.

SEC. 20. Section 77 of the Labor Code is amended to read:

77. (a) The commission shall conduct a continuing examination of the workers' compensation system, as defined in Section 4 of Article XIV of the California Constitution, and of the state's activities to prevent industrial injuries and occupational diseases. The commission may conduct or contract for studies it deems necessary to carry out its responsibilities. In carrying out its duties, the commission shall examine

other states' workers' compensation programs and activities to prevent industrial injuries and occupational diseases. All state departments and agencies, and any rating organization licensed by the Insurance Commissioner pursuant to Article 3 (commencing with Section 11750) of Chapter 3 of Part 3 of Division 2 of the Insurance Code, shall cooperate with the commission and upon reasonable request provide information and data in their possession that the commission deems necessary for the purpose of carrying out its responsibilities. The commission shall issue an annual report on the state of the workers' compensation system, including recommendations for administrative or legislative modifications which would improve the operation of the system. The report shall be made available to the Governor, the Legislature, and the public on request.

(b) On or before July 1, 2003, and periodically thereafter as it deems necessary, the commission shall issue a report and recommendations on the improvement and simplification of the notices required to be provided by insurers and self-insured employers.

(c) The commission succeeds to, and is vested with, all of the powers, duties, purposes, responsibilities, and jurisdiction of the Health and Safety Commission which is hereby abolished, including the administration of grants to assist in establishing effective occupational injury and illness prevention programs.

SEC. 21. Section 78 of the Labor Code is amended to read:

78. (a) The commission shall review and approve applications from employers and employee organizations, as well as applications submitted jointly by an employer organization and an employee organization, for grants to assist in establishing effective occupational injury and illness prevention programs. The commission shall establish policies for the evaluation of these applications and shall give priority to applications proposing to target high-risk industries and occupations, including those with high injury or illness rates, and those in which employees are exposed to one or more hazardous substances or conditions or where there is a demonstrated need for research to determine effective strategies for the prevention of occupational illnesses or injuries.

(b) Civil and administrative penalties assessed and collected pursuant to Sections 129.5 and 4628 shall be deposited in the Workers' Compensation Administration Revolving Fund. Moneys in the fund, when appropriated by the Legislature, shall be expended by the department, upon approval by the commission, for funding the grants under subdivision (a), and by the commission for payment of the commission's expenses incurred under this chapter.

SEC. 22. Section 90.3 is added to the Labor Code, to read:

90.3. (a) It is the policy of this state to vigorously enforce the laws requiring employers to secure the payment of compensation as required by Section 3700 and to protect employers who comply with the law from those who attempt to gain a competitive advantage at the expense of their workers by failing to secure the payment of compensation.

(b) In order to ensure that the laws requiring employers to secure the payment of compensation are adequately enforced, the Labor Commissioner shall establish and maintain a program for targeting employers in industries with the highest incidence of unlawfully uninsured employers. The industries and employers shall be identified from data from the Uninsured Employers' Fund, the Employment Development Department, the rating organizations licensed by the Insurance Commissioner pursuant to Article 3 (commencing with Section 11750) of Chapter 3 of Part 3 of Division 2 of the Insurance Code, and any other sources deemed likely to lead to the identification of unlawfully uninsured employers. All state departments and agencies and any rating organization licensed by the Insurance Commissioner pursuant to Article 3 (commencing with Section 11750) of Chapter 3 of Part 3 of Division 2 of the Insurance Code shall cooperate with the Labor Commissioner and on reasonable request provide information and data in their possession reasonably necessary to carry out the program.

(c) As part of the program, the Labor Commissioner shall establish procedures for ensuring that employers with payroll but with no record of workers' compensation coverage are contacted and, if no valid reason for the lack of record of coverage is shown, inspected on a priority basis.

(d) The Labor Commissioner shall annually report to the Legislature, not later than March 1, concerning the effectiveness of the program. The report shall include, but not be limited to, all of the following:

(1) The number of unlawfully uninsured employers identified pursuant to the program.

(2) The number of employers matched to records of insurance coverage.

(3) The number of employers notified that there was no record of their insurance coverage.

(4) The number of employers inspected.

(5) The number and amount of penalties assessed pursuant to Section 3722 as a result of the program.

SEC. 23. Section 90.5 of the Labor Code is amended to read:

90.5. (a) It is the policy of this state to vigorously enforce minimum labor standards in order to ensure employees are not required or permitted to work under substandard unlawful conditions or for employers that have not secured the payment of compensation, and to protect employers who comply with the law from those who attempt to

gain a competitive advantage at the expense of their workers by failing to comply with minimum labor standards.

(b) In order to ensure that minimum labor standards are adequately enforced, the Labor Commissioner shall establish and maintain a field enforcement unit, which shall be administratively and physically separate from offices of the division that accept and determine individual employee complaints. The unit shall have offices in Los Angeles, San Francisco, San Jose, San Diego, Sacramento, and any other locations that the Labor Commissioner deems appropriate. The unit shall have primary responsibility for administering and enforcing those statutes and regulations most effectively enforced through field investigations, including Sections 226, 1021, 1021.5, 1193.5, 1193.6, 1194.5, 1197, 1198, 1771, 1776, 1777.5, 2651, 2673, 2675, and 3700, in accordance with the plan adopted by the Labor Commissioner pursuant to subdivision (c). Nothing in this section shall be construed to limit the authority of this unit in enforcing any statute or regulation in the course of its investigations.

(c) The Labor Commissioner shall adopt an enforcement plan for the field enforcement unit. The plan shall identify priorities for investigations to be undertaken by the unit that ensure the available resources will be concentrated in industries, occupations, and areas in which employees are relatively low paid and unskilled, and those in which there has been a history of violations of the statutes cited in subdivision (b), and those with high rates of noncompliance with Section 3700.

(d) The Labor Commissioner shall annually report to the Legislature, not later than March 1, concerning the effectiveness of the field enforcement unit. The report shall include, but not be limited to, all of the following:

(1) The enforcement plan adopted by the Labor Commissioner pursuant to subdivision (c), and the rationale for the priorities identified in the plan.

(2) The number of establishments investigated by the unit, and the number of types of violations found.

(3) The amount of wages found to be unlawfully withheld from workers, and the amount of unpaid wages recovered for workers.

(4) The amount of penalties and unpaid wages transferred to the General Fund as a result of the efforts of the unit.

SEC. 23.5. The heading of Chapter 5 (commencing with Section 110) of Division 1 of the Labor Code is amended to read:

CHAPTER 5. DIVISION OF WORKERS' COMPENSATION

SEC. 24. Section 110 of the Labor Code is amended to read:

110. As used in this chapter:

(a) ''Appeals board'' means the Workers' Compensation Appeals Board. The title of a member of the board is ''commissioner.''

(b) ''Administrative director'' means the Administrative Director of the Division of Workers' Compensation.

(c) ''Division'' means the Division of Workers' Compensation.

(d) ''Medical director'' means the physician appointed by the Industrial Medical Council pursuant to Section 122.

(e) ''Qualified medical evaluator'' means physicians appointed by the Industrial Medical Council pursuant to Section 139.2.

(f) ''Court administrator'' means the administrator of the workers' compensation adjudicatory process at the trial level.

SEC. 25. Section 123 of the Labor Code is amended to read:

123. The administrative director may employ necessary assistants, officers, experts, statisticians, actuaries, accountants, workers' compensation administrative law judges, stenographic shorthand reporters, legal secretaries, disability evaluation raters, program technicians, and other employees to implement new, efficient court management systems. The salaries of the workers' compensation administrative law judges shall be fixed by the Department of Personnel Administration for a class of positions which perform judicial functions.

SEC. 26. Section 123.3 of the Labor Code is amended to read:

123.3. Any official reporter employed by the administrative director shall render stenographic or clerical assistance as directed by the presiding workers' compensation administrative law judge of the office to which the reporter is assigned, when the presiding workers' compensation administrative law judge determines that the reporter is not engaged in the performance of any other duty imposed by law.

SEC. 27. Section 123.5 of the Labor Code is amended to read:

123.5. (a) Workers' compensation administrative law judges employed by the administrative director and supervised by the court administrator pursuant to this chapter shall be taken from an eligible list of attorneys licensed to practice law in this state, who have the qualifications prescribed by the State Personnel Board. In establishing eligible lists for this purpose, state civil service examinations shall be conducted in accordance with the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code). Every workers' compensation judge shall maintain membership in the State Bar of California during his or her tenure.

A workers' compensation administrative law judge may not receive his or her salary as a workers' compensation administrative law judge while any cause before the workers' compensation administrative law judge remains pending and undetermined for 90 days after it has been submitted for decision.

(b) All workers' compensation administrative law judges appointed on or after January 1, 2003, shall be attorneys licensed to practice law in California for five or more years prior to their appointment and shall have experience in workers' compensation law.

(c) All workers' compensation administrative law judges shall be subject to the jurisdiction of the Commission on Judicial Performance.

SEC. 28. Section 123.6 of the Labor Code is amended to read:

123.6. (a) All workers' compensation administrative law judges employed by the administrative director and supervised by the court administrator shall subscribe to the Code of Judicial Ethics adopted by the Supreme Court pursuant to subdivision (m) of Section 18 of Article VI of the California Constitution for the conduct of judges and shall not otherwise, directly or indirectly, engage in conduct contrary to that code or to the commentary to the Code of Judicial Ethics made by the California Judges Association.

The administrative director shall adopt regulations to enforce this section after consideration of recommendations from the court administrator. Existing regulations shall remain in effect until new regulations based on the recommendations of the court administrator have become effective. To the extent possible, the rules shall be consistent with the procedures established by the Commission on Judicial Performance for regulating the activities of state judges, and, to the extent possible, with the gift, honoraria, and travel restrictions on legislators contained in the Political Reform Act of 1974 (Title 9 (commencing with Section 81000) of the Government Code).

(b) Honoraria or travel allowed by the court administrator, and not otherwise prohibited by this section in connection with any public or private conference, convention, meeting, social event, or like gathering, the cost of which is significantly paid for by attorneys who practice before the board, may not be accepted unless the court administrator has provided prior approval in writing to the workers' compensation administrative law judge allowing him or her to accept those payments.

SEC. 29. Section 124 of the Labor Code is amended to read:

124. (a) In administering and enforcing this division and Division 4 (commencing with Section 3200), the division shall protect the interests of injured workers who are entitled to the timely provision of compensation.

(b) The administrative director, in consultation with the court administrator, shall advise the Industrial Medical Council on a form adopted by the council whether individual qualified medical evaluators have prepared formal medical evaluations that can be satisfactorily rated by the office.

(c) Forms and notices required to be given to employees by the division shall be in English and Spanish.

SEC. 30. Section 127 of the Labor Code is amended to read:

127. The administrative director and court administrator may:

(a) Charge and collect fees for copies of papers and records, for certified copies of official documents and orders or of the evidence taken or proceedings had, for transcripts of testimony, and for inspection of case files not stored in the place where the inspection is requested. The administrative director shall fix those fees in an amount sufficient to recover the actual costs of furnishing the services. No fees for inspection of case files shall be charged to an injured employee or his or her representative.

(b) Publish and distribute from time to time, in addition to the reports to the Governor, further reports and pamphlets covering the operations, proceedings, and matters relative to the work of the division.

(c) Prepare, publish, and distribute an office manual, for which a reasonable fee may be charged, and to which additions, deletions, amendments, and other changes from time to time may be adopted, published, and distributed, for which a reasonable fee may be charged for the revision, or for which a reasonable fee may be fixed on an annual subscription basis.

(d) Fix and collect reasonable charges for publications issued.

SEC. 31. Section 127.5 is added to the Labor Code, to read:

127.5. In the exercise of his or her functions, the court administrator shall further the interests of uniformity and expedition of proceedings before workers' compensation administrative law judges, assure that all workers' compensation administrative law judges are qualified and adhere to deadlines mandated by law or regulations, and manage district office procedural matters at the trial level.

SEC. 32. Section 127.6 is added to the Labor Code, to read:

127.6. (a) The administrative director shall, in consultation with the Commission on Health and Safety and Workers' Compensation, the Industrial Medical Council, other state agencies, and researchers and research institutions with expertise in health care delivery and occupational health care service, conduct a study of medical treatment provided to workers who have sustained industrial injuries and illnesses. The study shall focus on, but not be limited to, all of the following:

(1) Factors contributing to the rising costs and utilization of medical treatment and case management in the workers' compensation system.

(2) An evaluation of case management procedures that contribute to or achieve early and sustained return to work within the employee's temporary and permanent work restrictions.

(3) Performance measures for medical services that reflect patient outcomes.

(4) Physician utilization, quality of care, and outcome measurement data.

(5) Patient satisfaction.

(b) The administrative director shall begin the study on or before July 1, 2003, and shall report and make recommendations to the Legislature based on the results of the study on or before July 1, 2004.

(c) In implementing this section, the administrative director shall ensure the confidentiality and protection of patient-specific data.

SEC. 33. Section 129 of the Labor Code is amended to read:

129. (a) To make certain that injured workers, and their dependents in the event of their death, receive promptly and accurately the full measure of compensation to which they are entitled, the administrative director shall audit insurers, self-insured employers, and third-party administrators to determine if they have met their obligations under this code. Each audit subject shall be audited at least once every five years. The audit subjects shall be selected and the audits conducted pursuant to subdivision (b). The results of audits of insurers shall be provided to the Insurance Commissioner, and the results of audits of self-insurers and third-party administrators shall be provided to the Director of Industrial Relations. Nothing in this section shall restrict the authority of the Director of Industrial Relations or the Insurance Commissioner to audit their licensees.

(b) The administrative director shall schedule and conduct audits as follows:

(1) A profile audit review of every audit subject shall be conducted once every five years and on additional occasions indicated by target audit criteria. The administrative director shall annually establish a profile audit review performance standard that will identify the poorest performing audit subjects.

(2) A full compliance audit shall be conducted of each profile audited subject failing to meet or exceed the profile audit review performance standard. The full compliance audit shall be a comprehensive and detailed evaluation of the audit subject's performance. The administrative director shall annually establish a full compliance audit performance standard that will identify the audit subjects that are performing satisfactorily. Any full compliance audit subject that fails to

meet or exceed the full compliance audit performance standard shall be audited again within two years.

(3) A targeted profile audit review or a full compliance audit may be conducted at any time in accordance with target audit criteria adopted by the administrative director. The target audit criteria shall be based on information obtained from benefit notices, from information and assistance officers, and from other reliable sources providing factual information that indicates an insurer, self-insured employer, or third-party administrator is failing to meet its obligations under this division or Division 4 (commencing with Section 3200) or the regulations of the administrative director.

(c) If, as a result of a profile audit review or a full compliance audit, the administrative director determines that any compensation, interest, or penalty is due and unpaid to an employee or dependent, the administrative director shall issue and cause to be served upon the insurer, self-insured employer, or third-party administrator a notice of assessment detailing the amounts due and unpaid in each case, and shall order the amounts paid to the person entitled thereto. The notice of assessment shall be served personally or by registered mail in accordance with subdivision (c) of Section 11505 of the Government Code. A copy of the notice of assessment shall also be sent to the affected employee or dependent.

If the amounts are not paid within 30 days after service of the notice of assessment, the employer shall also be liable for reasonable attorney's fees necessarily incurred by the employee or dependent to obtain amounts due. The administrative director shall advise each employee or dependent still owed compensation after this 30-day period of his or her rights with respect to the commencement of proceedings to collect the compensation owed. Amounts unpaid because the person entitled thereto cannot be located shall be paid to the Workers' Compensation Administration Revolving Fund. The Director of Industrial Relations shall promulgate rules and regulations establishing standards and procedures for the payment of compensation from moneys deposited in the Workers' Compensation Administration Revolving Fund whenever the person entitled thereto applies for compensation.

(d) A determination by the administrative director that an amount is or is not due to an employee or dependent shall not in any manner limit the jurisdiction or authority of the appeals board to determine the issue.

(e) Annually, commencing on April 1, 1991, the administrative director shall publish a report detailing the results of audits conducted pursuant to this section during the preceding calendar year. The report shall include the name of each insurer, self-insured employer, and third-party administrator audited during that period. For each insurer,

self-insured employer, and third-party administrator audited, the report shall specify the total number of files audited, the number of violations found by type and amount of compensation, interest and penalties payable, and the amount collected for each violation. The administrative director shall also publish and make available to the public on request a list ranking all insurers, self-insured employers, and third-party administrators audited during the period according to their performance measured by the profile audit review and full compliance audit performance standards.

These reports shall not identify the particular claim file that resulted in a particular violation or penalty. Except as required by this subdivision or other provisions of law, the contents of individual claim files and auditor's working papers shall be confidential. Disclosure of claim information to the administrative director pursuant to an audit shall not waive the provisions of the Evidence Code relating to privilege.

(f) A profile audit review of the adjustment of claims against the Uninsured Employers Fund by the claims and collections unit of the Division of Workers' Compensation shall be conducted at least every five years. The results of this profile audit review shall be included in the report required by subdivision (e).

SEC. 34. Section 129.5 of the Labor Code is amended to read:

129.5. (a) The administrative director may assess an administrative penalty against an insurer, self-insured employer, or third-party administrator for any of the following:

(1) Failure to comply with the notice of assessment issued pursuant to subdivision (c) of Section 129 within 15 days of receipt.

(2) Failure to pay when due the undisputed portion of an indemnity payment, the reasonable cost of medical treatment of an injured worker, or a charge or cost implementing an approved vocational rehabilitation plan.

(3) Failure to comply with any rule or regulation of the administrative director.

(b) The administrative director shall promulgate regulations establishing a schedule of violations and the amount of the administrative penalty to be imposed for each type of violation. The schedule shall provide for imposition of a penalty of up to one hundred dollars ($100) for each violation of the less serious type and for imposition of penalties in progressively higher amounts for the most serious types of violations to be set at up to five thousand dollars ($5,000) per violation. The administrative director is authorized to impose penalties pursuant to rules and regulations which give due consideration to the appropriateness of the penalty with respect to the following factors:

(1) The gravity of the violation.

(2) The good faith of the insurer, self-insured employer, or third-party administrator.

(3) The history of previous violations, if any.

(4) The frequency of the violations.

(5) Whether the audit subject has met or exceeded the profile audit review performance standard.

(6) Whether a full compliance audit subject has met or exceeded the full compliance audit performance standard.

(7) The size of the audit subject location.

(c) The administrative director shall assess penalties as follows:

(1) If, after a profile audit review, the administrative director determines that the profile audit subject met or exceeded the profile audit review performance standard, no penalties shall be assessed under this section, but the audit subject shall be required to pay any compensation due and penalties due under subdivision (d) of Section 4650 as provided in subdivision (c) of Section 129.

(2) If, after a full compliance audit, the administrative director determines that the audit subject met or exceeded the full compliance audit performance standards, penalties for unpaid or late paid compensation, but no other penalties under this section, shall be assessed. The audit subject shall be required to pay any compensation due and penalties due under subdivision (d) of Section 4650 as provided in subdivision (c) of Section 129.

(3) If, after a full compliance audit, the administrative director determines that the audit subject failed to meet the full compliance audit performance standards, penalties shall be assessed as provided in a full compliance audit failure penalty schedule to be adopted by the administrative director. The full compliance audit failure penalty schedule shall adjust penalty levels relative to the size of the audit location to mitigate inequality between total penalties assessed against small and large audit subjects. The penalty amounts provided in the full compliance audit failure penalty schedule for the most serious type of violations shall not be limited by subdivision (b), but in no event shall the penalty for a single violation exceed forty thousand dollars ($40,000).

(d) The notice of penalty assessment shall be served personally or by registered mail in accordance with subdivision (c) of Section 11505 of the Government Code. The notice shall be in writing and shall describe the nature of the violation, including reference to the statutory provision or rule or regulation alleged to have been violated. The notice shall become final and the assessment shall be paid unless contested within

15 days of receipt by the insurer, self-insured employer, or third-party administrator.

(e) In addition to the penalty assessments permitted by subdivisions (a), (b), and (c), the administrative director may assess a civil penalty, not to exceed one hundred thousand dollars ($100,000), upon finding, after hearing, that an employer, insurer, or third-party administrator for an employer has knowingly committed or performed with sufficient frequency so as to indicate a general business practice any of the following:

(1) Induced employees to accept less than compensation due, or made it necessary for employees to resort to proceedings against the employer to secure compensation.

(2) Refused to comply with known and legally indisputable compensation obligations.

(3) Discharged or administered compensation obligations in a dishonest manner.

(4) Discharged or administered compensation obligations in a manner as to cause injury to the public or those dealing with the employer or insurer.

Any employer, insurer, or third-party administrator that fails to meet the full compliance audit performance standards in two consecutive full compliance audits shall be rebuttably presumed to have engaged in a general business practice of discharging and administering its compensation obligations in a manner causing injury to those dealing with it.

Upon a second or subsequent finding, the administrative director shall refer the matter to the Insurance Commissioner or the Director of Industrial Relations and request that a hearing be conducted to determine whether the certificate of authority, certificate of consent to self-insure, or certificate of consent to administer claims of self-insured employers, as the case may be, shall be revoked.

(f) An insurer, self-insured employer, or third-party administrator may file a written request for a conference with the administrative director within seven days after receipt of a notice of penalty assessment issued pursuant to subdivision (a) or (c). Within 15 days of the conference, the administrative director shall issue a notice of findings and serve it upon the contesting party by registered or certified mail. Any amount found due by the administrative director shall become due and payable 30 days after receipt of the notice of findings. The 30-day period shall be tolled during any appeal. A writ of mandate may be taken from the findings to the appropriate superior court upon the execution by the contesting party of a bond to the state in the principal sum that is double the amount found due and ordered by the administrative director, on the

condition that the contesting party shall pay any judgment and costs rendered against it for the amount.

(g) An insurer, self-insured employer, or third-party administrator may file a written request for a hearing before the Workers' Compensation Appeals Board within seven days after receipt of a notice of penalty assessment issued pursuant to subdivision (e). Within 30 days of the hearing, the appeals board shall issue findings and orders and serve them upon the contesting party in the manner provided in its rules. Any amount found due by the appeals board shall become due and payable 45 days after receipt of the notice of findings. Judicial review of the findings and order shall be had in the manner provided by Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4. The 45-day period shall be tolled during appellate proceedings upon execution by the contesting party of a bond to the state in a principal sum that is double the amount found due and ordered by the appeals board on the condition that the contesting party shall pay the amount ultimately determined to be due and any costs awarded by an appellate court.

(h) Nothing in this section shall create nor eliminate a civil cause of action for the employee and his or her dependents.

(i) All moneys collected under this section shall be deposited in the State Treasury and credited to the Workers' Compensation Administration Revolving Fund.

SEC. 35. Section 133 of the Labor Code is amended to read:

133. The Division of Workers' Compensation, including the administrative director, the court administrator, and the appeals board, shall have power and jurisdiction to do all things necessary or convenient in the exercise of any power or jurisdiction conferred upon it under this code.

SEC. 36. Section 138 of the Labor Code is amended to read:

138. The administrative director and the court administrator may each appoint a deputy to act during that time as he or she may be absent from the state due to official business, vacation, or illness.

SEC. 37. Section 138.1 of the Labor Code is amended to read:

138.1. (a) The administrative director shall be appointed by the Governor with the advice and consent of the Senate and shall hold office at the pleasure of the Governor. He or she shall receive the salary provided for by Chapter 6 (commencing with Section 11550) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) The court administrator shall be appointed by the Governor with the advice and consent of the Senate. The court administrator shall hold office at the pleasure of the administrative director. The court administrator shall receive the salary provided for by Chapter 6

(commencing with Section 11550) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 38. Section 138.2 of the Labor Code is amended to read:

138.2. (a) The headquarters of the Division of Workers' Compensation shall be based at and operated from a centrally located city.

The administrative director and the court administrator shall have an office in that city with suitable rooms, necessary office furniture, stationery, and supplies, and may rent quarters in other places for the purpose of establishing branch or service offices, and for that purpose may provide those offices with necessary furniture, stationery and supplies.

(b) The administrative director shall provide suitable rooms, with necessary office furniture, stationery and supplies, for the appeals board at the centrally located city in which the board shall be based and from which it shall operate, and may rent quarters in other places for the purpose of establishing branch or service offices for the appeals board, and for that purpose may provide those offices with necessary furniture, stationery, and supplies.

(c) All meetings held by the administrative director shall be open and public. Notice thereof shall be published in papers of general circulation not more than 30 days and not less than 10 days prior to each meeting in Sacramento, San Francisco, Fresno, Los Angeles and San Diego. Written notice of all meetings shall be given to all persons who request in writing directed to the administrative director that they be given notice.

SEC. 39. Section 138.4 of the Labor Code is amended to read:

138.4. (a) For the purpose of this section, ''claims administrator'' means a self-administered workers' compensation insurer; or a self-administered self-insured employer; or a self-administered legally uninsured employer; or a self-administered joint powers authority; or a third-party claims administrator for an insurer, a self-insured employer, a legally uninsured employer, or a joint powers authority.

(b) With respect to injuries resulting in lost time beyond the employee's work shift at the time of injury or medical treatment beyond first aid:

(1) If the claims administrator obtains knowledge that the employer has not provided a claim form or a notice of potential eligibility for benefits to the employee, it shall provide the form and notice to the employee within three working days of its knowledge that the form or notice was not provided.

(2) If the claims administrator cannot determine if the employer has provided a claim form and notice of potential eligibility for benefits to

the employee, the claims administrator shall provide the form and notice to the employee within 30 days of the administrator's date of knowledge of the claim.

(c) The administrative director shall prescribe reasonable rules and regulations for serving on the employee (or employee's dependents, in the case of death), notices dealing with the payment, nonpayment, or delay in payment of temporary disability, permanent disability, and death benefits and the provision of vocational rehabilitation services, notices of any change in the amount or type of benefits being provided, the termination of benefits, the rejection of any liability for compensation, and an accounting of benefits paid.

SEC. 39.5. Section 139.05 of the Labor Code is repealed.

SEC. 40. Section 139.47 is added to the Labor Code, to read:

139.47. The Director of Industrial Relations shall establish and maintain a program to encourage, facilitate, and educate employers to provide early and sustained return to work after occupational injury or illness. The program shall do both of the following:

(a) Develop educational materials and guides, in easily understandable language in both print and electronic form, for employers, health care providers, employees, and labor unions. These materials shall address issues including, but not limited to, early return to work, assessment of functional abilities and limitations, development of appropriate work restrictions, job analysis, worksite modifications, assistive equipment and devices, and available resources.

(b) Conduct training for employee and employer organizations and health care providers concerning the accommodation of injured employees and the prevention of reinjury.

SEC. 41. Section 139.48 is added to the Labor Code, to read:

139.48. (a) The administrative director shall establish the Return-to-Work Program in order to promote the early and sustained return to work of the employee following a work-related injury or illness.

(b) Upon submission by employers of documentation in accordance with regulations adopted pursuant to subdivision (h), the administrative director shall pay the wage reimbursement, workplace modification expense reimbursement, and premium reimbursement allowed under this section.

(c) Any employer, except the state or an employer eligible to secure the payment of compensation pursuant to subdivision (c) of Section 3700, may apply for a reimbursement for wages paid to an employee who has returned to modified or alternative work, as defined in paragraphs (5) and (6) of subdivision (a) of Section 4644, with the

employer during the period the employee is temporarily disabled from his or her employment in accordance with all of the following:

(1) The reimbursement shall be allowed for up to 50 percent of wages paid to the employee.

(2) The reimbursement shall be allowed for a period of no more than 90 days, or until the employee is released to the full duties of his or her usual occupation, or until the employee's condition becomes permanent and stationary, whichever occurs first.

(3) The modified or alternative work is compatible with the employee's documented work restrictions imposed by the treating physician as a result of the work injury or illness.

(4) The reimbursement shall be paid from the Workers' Compensation Return-to-Work Fund, created in subdivision (i), as a reimbursement to the employer after submission of documentation of eligibility and wages paid.

(d) The administrative director shall reimburse an employer for expenses incurred to make workplace modifications to accommodate the employee's return to modified or alternative work, as follows:

(1) The maximum reimbursement to an employer for expenses to accommodate each temporarily disabled injured worker is one thousand two hundred fifty dollars ($1,250).

(2) The maximum reimbursement to an employer for expenses to accommodate each permanently disabled worker who is a qualified injured worker is two thousand five hundred dollars ($2,500). If the employer received reimbursement under paragraph (1), the amount of the reimbursement under paragraph (1) and this paragraph shall not exceed two thousand five hundred dollars ($2,500).

(3) The modification expenses shall be incurred in order to allow a temporarily disabled worker to perform modified or alternative work within physician-imposed temporary work restrictions, or to allow a permanently disabled worker who is a qualified injured worker to return to sustained modified or alternative employment with the employer within physician-imposed permanent work restrictions.

(4) Allowable expenses may include physical modifications to the worksite, equipment, devices, furniture, tools, or other necessary costs for accommodation of the employee's restrictions.

(e) (1) An insured employer may apply to the administrative director for reimbursement of workers' compensation insurance premiums attributable to the sustained employment of a qualified injured worker following the period for premium rebate provided in subdivision (a) of Section 4638. The reimbursement shall be equal to the standard premium computed on the wages paid by the employer to the qualified injured worker during each 12-month period.

(2) An employer that employs 100 or fewer employees on the date of injury may be reimbursed for 100 percent of the workers' compensation insurance premium paid for the employee for up to two years. An employer that employs more than 100 employees on the date of injury may be reimbursed for 50 percent of the workers' compensation insurance premium paid for the employee for up to two years. The period subject to premium reimbursement shall begin on the first day after the end of the 12-month period for premium rebate provided in subdivision (a) of Section 4638 and shall continue for a maximum of two years.

(3) The premium reimbursement shall be paid to the employer annually after each consecutive period of 12 months, provided that the qualified injured worker continues modified or alternative employment with that employer in a regular position that pays at least 85 percent of the employee's pre-injury wages and compensation.

(f) This section shall not create a preference in employment for injured employees over noninjured employees. It shall be unlawful for an employer to discriminatorily terminate, lay off, demote, or otherwise displace an employee in order to return an industrially injured employee to employment for the purpose of obtaining the reimbursement set forth in subdivisions (c), (d), or (e).

(g) For purposes of this section, ''employee'' means a worker who has suffered a work-related injury or illness on or after July 1, 2004.

(h) The administrative director shall adopt regulations to carry out this section. Regulations allocating budget funds that are insufficient to implement the maximum wage reimbursement, workplace modification expense reimbursement, and premium reimbursement provided for in this section shall include a prioritization schema according to which employers with less than 100 employees shall be given preference in the allocation of those funds.

(i) The Workers' Compensation Return-to-Work Fund is hereby created as a special fund in the State Treasury. The fund shall be administered by the administrative director. Moneys in the fund may be expended by the administrative director, upon appropriation by the Legislature, only for purposes of implementing this section. The unencumbered balance remaining in the fund as of January 1, 2009, shall revert to the General Fund.

(j) This section shall be operative on July 1, 2004.

(k) This section shall not be implemented unless and until funds are appropriated by the Legislature for this purpose in the annual Budget Act or other statute commencing with the 2004–05 fiscal year.

(*l*) This section shall remain in effect only until January 1, 2009, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends that date.

SEC. 41.5. Section 139.49 is added to the Labor Code, to read:

139.49. (a) The administrative director shall contract with an independent research organization to conduct a study and issue a report on the Return-to-Work Program established in Section 139.48. The study shall examine at least two years' operation of the program and shall address all of the following:

(1) The effectiveness of the wage reimbursement, workplace modification expense reimbursement, and premium reimbursement components of the program.

(2) The rate of participation by insured and self-insured employers, including information on the size and industry of employers.

(3) Comparison of rates of utilization of modified and alternative work before and after establishment of the program and evaluation of whether there is an increase in sustained return to work.

(4) The impact of the program on injured employees.

(5) The cost-effectiveness of the program.

(6) Identification of potential future funding mechanisms for the program.

(b) On or before January 1, 2008, the administrative director shall make the report available to the public and the Legislature.

(c) This section shall remain in effect only until January 1, 2009, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2009, deletes or extends that date.

SEC. 42. Section 3201.7 is added to the Labor Code, to read:

3201.7. (a) Except as provided in subdivisions (b) and (c), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any provision in a collective bargaining agreement between a private employer or groups of employers engaged in the aerospace or timber industries and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:

(1) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a final order, decision, or award made and filled by a workers' compensation judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeals pursuant to the procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards

of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.

(2) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.

(3) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.

(4) Joint labor management safety committees.

(5) A light-duty, modified job or return-to-work program.

(6) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division.

(b) Nothing in this section shall allow a collective bargaining agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division; nor shall any agreement authorized by this section deny to any employee the right to representation by counsel at all stages of the alternative dispute resolution process. The portion of any agreement that violates this subdivision shall be declared null and void.

(c) Subdivision (a) shall apply only to the following:

(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) or more, or any employer that paid an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000), in at least one of the previous three years.

(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees, which develops or projects annual workers' compensation insurance premiums of two million dollars ($2,000,000) or more.

(3) Employer or groups of employers that are self-insured in compliance with Section 3700 that would have projected annual workers' compensation costs that meet the requirements of paragraph

(1) in the case of employers, or paragraph (2) in the case of groups of employers.

(d) Employers and labor representatives who meet the eligibility requirements of this section shall be issued a letter by the administrative director advising each employer and labor representative that, based upon the review of all documents and materials submitted as required by the administrative director, each has met the eligibility requirements of this section.

(e) The premium rate for a policy of insurance issued pursuant to this section shall not be subject to the requirements of Section 11732 or 11732.4 of the Insurance Code.

(f) No employer may establish or continue a program established under this section until it has provided the administrative director with all of the following:

(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the collective bargaining agreement and the approximate number of employees who will be covered thereby.

(2) Upon its original application and annually thereafter, a valid and active license where that license is required by law as a condition of doing business in the state within the industries set forth in subdivision (a).

(3) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement.

(4) The name, address, and telephone number of the contact person of the employer.

(5) Upon its original application, a plan agreed to between an employer and any affected union prior to the commencement of collective bargaining, that establishes a framework for the implementation of the system to be developed pursuant to subdivision (a).

(6) Any other information that the administrative director deems necessary to further the purposes of this section.

(g) No collective bargaining representative may establish or continue to participate in a program established under this section unless all of the following requirements are met:

(1) Upon its original application and annually thereafter, it has provided to the administrative director a copy of its most recent LM-2 or LM-3 filing with the United States Department of Labor, along with a statement, signed under penalty of perjury, that the document is a true and correct copy.

(2) It has provided to the administrative director the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.

(h) Commencing July 1, 2004, and annually thereafter, the Division of Workers' Compensation shall report to the Director of Industrial Relations the number of collective bargaining agreements received and the number of employees covered by these agreements.

(i) By June 30, 2004, and annually thereafter, the Administrative Director of the Division of Workers' Compensation shall prepare and notify members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:

(1) Person hours and payroll covered by agreements filed.

(2) The number of claims filed.

(3) The average cost per claim shall be reported by cost components whenever practicable.

(4) The number of litigated claims, including the number of claims submitted to mediation, the appeals board, or the court of appeals.

(5) The number of contested claims resolved prior to arbitration.

(6) The projected incurred costs and actual costs of claims.

(7) Safety history.

(8) The number of workers participating in vocational rehabilitation.

(9) The number of workers participating in light-duty programs.

(10) Overall worker satisfaction.

The division shall have the authority to require those employers and groups of employers listed in subdivision (c) to provide the data listed above.

(j) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (h) and (i) based on the collective bargaining agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis the administrative director shall make available an updated list of employers and unions entering into collective bargaining agreements containing provisions authorized by this section.

SEC. 42.5. Section 3201.9 is added to the Labor Code, to read:

3201.9. (a) On or before June 30, 2004, and biannually thereafter, the report required in subdivision (i) of Section 3201.5 and subdivision (i) of Section 3201.7 shall include updated loss experience for all employers and groups of employers participating in a program established under those sections. The report shall include updated data on each item set forth in subdivision (i) of Section 3201.5 and

subdivision (i) of Section 3201.7 for the previous year for injuries in 2003 and beyond. Updates for each program shall be done for the original program year and for subsequent years. The insurers, the Department of Insurance, and the rating organization designated by the Insurance Commissioner pursuant to Article 3 (commencing with Section 11750) of Chapter 3 of Part 3 of Division 2 of the Insurance Code, shall provide the administrative director with any information that the administrative director determines is reasonably necessary to conduct the study.

(b) Commencing on and after June 30, 2004, the Insurance Commissioner, or the commissioner's designee, shall prepare for inclusion in the report required in subdivision (i) of Section 3201.5 and subdivision (i) of Section 3201.7 a review of both of the following:

(1) The adequacy of rates charged for these programs, including the impact of scheduled credits and debits.

(2) The comparative results for these programs with other programs not subject to Section 3201.5 or Section 3201.7.

(c) Upon completion of the report, the administrative director shall report the findings to the Legislature, the Department of Insurance, the designated rating organization, and the programs and insurers participating in the study.

(d) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state.

SEC. 43. Section 3501 of the Labor Code is amended to read:

3501. (a) A child under the age of 18 years, or a child of any age found by any trier of fact, whether contractual, administrative, regulatory, or judicial, to be physically or mentally incapacitated from earning, shall be conclusively presumed to be wholly dependent for support upon a deceased employee-parent with whom that child is living at the time of injury resulting in death of the parent or for whose maintenance the parent was legally liable at the time of injury resulting in death of the parent, there being no surviving totally dependent parent.

(b) A spouse to whom a deceased employee is married at the time of death shall be conclusively presumed to be wholly dependent for support upon the deceased employee if the surviving spouse earned thirty thousand dollars ($30,000) or less in the twelve months immediately preceding the death.

(c) In the event that no person qualifies as a total or partial dependent of the deceased employee, then the surviving parent or parents of the deceased employee shall be conclusively presumed to be wholly dependent for support upon the deceased employee.

SEC. 44. Section 3550 of the Labor Code is amended to read:

3550. (a) Every employer subject to the compensation provisions of this division shall post and keep posted in a conspicuous location frequented by employees, and where the notice may be easily read by employees during the hours of the workday, a notice that states the name of the current compensation insurance carrier of the employer, or when such is the fact, that the employer is self-insured, and who is responsible for claims adjustment.

(b) Failure to keep any notice required by this section conspicuously posted shall constitute a misdemeanor, and shall be prima facie evidence of noninsurance.

(c) This section shall not apply with respect to the employment of employees as defined in subdivision (d) of Section 3351.

(d) The form and content of the notice required by this section shall be prescribed by the administrative director, after consultation with the Commission on Health and Safety and Workers' Compensation, and shall advise employees that all injuries should be reported to their employer. The notice shall be easily understandable. It shall be posted in both English and Spanish where there are Spanish-speaking employees. The notice shall include the following information:

(1) How to get emergency medical treatment, if needed.

(2) The kinds of events, injuries, and illnesses covered by workers' compensation.

(3) The injured employee's right to receive medical care.

(4) The rights of the employee to select and change the treating physician pursuant to the provisions of Section 4600.

(5) The rights of the employee to receive temporary disability indemnity, permanent disability indemnity, vocational rehabilitation services, and death benefits, as appropriate.

(6) To whom injuries should be reported.

(7) The existence of time limits for the employer to be notified of an occupational injury.

(8) The protections against discrimination provided pursuant to Section 132a.

(9) The location and telephone number of the nearest information and assistance officer.

(e) Failure of an employer to provide the notice required by this section shall automatically permit the employee to be treated by his or her personal physician with respect to an injury occurring during that failure.

(f) The form and content of the notice required to be posted by this section shall be made available to self-insured employers and insurers by the administrative director. Insurers shall provide this notice to each

of their policyholders, with advice concerning the requirements of this section and the penalties for a failure to post this notice.

SEC. 45. Section 3551 of the Labor Code is amended to read:

3551. (a) Every employer subject to the compensation provisions of this code, except employers of employees defined in subdivision (d) of Section 3351, shall give every new employee, either at the time the employee is hired or by the end of the first pay period, written notice of the information contained in Section 3550. The content of the notice required by this section shall be prescribed by the administrative director after consultation with the Commission on Health and Safety and Workers' Compensation.

(b) The notice required by this section shall be easily understandable and available in both English and Spanish. In addition to the information contained in Section 3550, the content of the notice required by this section shall include:

(1) Generally, how to obtain appropriate medical care for a job injury.

(2) The role and function of the primary treating physician.

(3) A form that the employee may use as an optional method for notifying the employer of the name of the employee's ''personal physician,'' as defined by Section 4600, or ''personal chiropractor,'' as defined by Section 4601.

(c) The content of the notice required by this section shall be made available to employers and insurers by the administrative director. Insurers shall provide this notice to each of their policyholders, with advice concerning the requirements of this section and the penalties for a failure to provide this notice to all employees.

SEC. 46. Section 3552 of the Labor Code is repealed.

SEC. 47. Section 3722 of the Labor Code is amended to read:

3722. (a) At the time the stop order is issued and served pursuant to Section 3710.1, the director shall also issue and serve a penalty assessment order requiring the uninsured employer to pay to the director, for deposit in the State Treasury to the credit of the Uninsured Employers Fund, the sum of one thousand dollars ($1,000) per employee employed at the time the order is issued and served, as an additional penalty for being uninsured at that time.

(b) At any time that the director determines that an employer has been uninsured for a period in excess of one week during the calendar year preceding the determination, the director may issue and serve a penalty assessment order requiring the uninsured employer to pay to the director, for deposit in the State Treasury to the credit of the Uninsured Employers Fund, the greater of (1) twice the amount the employer would have paid in workers' compensation premiums during the period the employer was uninsured, determined according to subdivision (c), or (2) the sum of one

thousand dollars ($1,000) per employee employed during the period the employer was uninsured. A penalty assessment issued and served by the director pursuant to this subdivision shall be in lieu of, and not in addition to, any other penalty issued and served by the director pursuant to subdivision (a).

(c) If the employer is currently insured, or becomes insured during the period during which the penalty under subdivision (b) is being determined, the amount an employer would have paid in workers' compensation premiums shall be calculated by prorating the current premium for the number of weeks the employer was uninsured. If the employer is uninsured at the time the penalty under subdivision (b) is being determined, the amount an employer would have paid in workers' compensation premiums shall be calculated by applying the weekly premium per employee calculated according to subdivision (d) of Section 11734 of the Insurance Code to the number of weeks the employer was uninsured. Each employee of the uninsured employer shall be assumed to be assigned to the governing classification for that employer as determined by the director after consultation with the Insurance Commissioner. If the employer contends that the assignment of the governing classification is incorrect, or that any employee should be assigned to a different classification, the employer has the burden to prove that the different classification should be utilized.

(d) If upon the filing of a claim for compensation under this division the Workers' Compensation Appeals Board finds that any employer has not secured the payment of compensation as required by this division and finds the claim either noncompensable or compensable, the appeals board shall mail a copy of their findings to the uninsured employer and the director, together with a direction to the uninsured employer to file a verified statement pursuant to subdivision (e).

After the time for any appeal has expired and the adjudication of the claim has become final, the uninsured employer shall be assessed and pay as a penalty either of the following:

(1) In noncompensable cases, two thousand dollars ($2,000) per each employee employed at the time of the claimed injury.

(2) In compensable cases, ten thousand dollars ($10,000) per each employee employed on the date of the injury.

(e) In order to establish the number of employees the uninsured employer had on the date of the claimed injury in noncompensable cases and on the date of injury in compensable cases, the employer shall submit to the director within 10 days after service of findings, awards, and orders of the Workers' Compensation Appeals Board a verified statement of the number of employees in his or her employ on the date of injury. If the employer fails to submit to the director this verified

statement or if the director disputes the accuracy of the number of employees reported by the employer, the director shall use any information regarding the number of employees as the director may have or otherwise obtains.

(f) Except for penalties assessed under subdivision (b), the maximum amount of penalties which may be assessed pursuant to this section is one hundred thousand dollars ($100,000). Payment shall be transmitted to the director for deposit in the State Treasury to the credit of the Uninsured Employers Fund.

(g) (1) The Workers' Compensation Appeals Board may provide for a summary hearing on the sole issue of compensation coverage to effect the provisions of this section.

(2) In the event a claim is settled by the director pursuant to subdivision (e) of Section 3715 by means of a compromise and release or stipulations with request for award, the appeals board may also provide for a summary hearing on the issue of compensability.

SEC. 48. Section 3762 of the Labor Code is amended to read:

3762. (a) Except as provided in subdivisions (b) and (c), the insurer shall discuss all elements of the claim file that affect the employer's premium with the employer, and shall supply copies of the documents that affect the premium at the employer's expense during reasonable business hours.

(b) The right provided by this section shall not extend to any document that the insurer is prohibited from disclosing to the employer under the attorney-client privilege, any other applicable privilege, or statutory prohibition upon disclosure, or under Section 1877.4 of the Insurance Code.

(c) An insurer, third-party administrator retained by a self-insured employer pursuant to Section 3702.1 to administer the employer's workers' compensation claims, and those employees and agents specified by a self-insured employer to administer the employer's workers' compensation claims, are prohibited from disclosing or causing to be disclosed to an employer, any medical information, as defined in subdivision (b) of Section 56.05 of the Civil Code, about an employee who has filed a workers' compensation claim, except as follows:

(1) Medical information limited to the diagnosis of the mental or physical condition for which workers' compensation is claimed and the treatment provided for this condition.

(2) Medical information regarding the injury for which workers' compensation is claimed that is necessary for the employer to have in order for the employer to modify the employee's work duties.

SEC. 49. Section 3820 of the Labor Code is amended to read:

3820. (a) In enacting this section, the Legislature declares that there exists a compelling interest in eliminating fraud in the workers' compensation system. The Legislature recognizes that the conduct prohibited by this section is, for the most part, already subject to criminal penalties pursuant to other provisions of law. However, the Legislature finds and declares that the addition of civil money penalties will provide necessary enforcement flexibility. The Legislature, in exercising its plenary authority related to workers' compensation, declares that these sections are both necessary and carefully tailored to combat the fraud and abuse that is rampant in the workers' compensation system.

(b) It is unlawful to do any of the following:

(1) Willfully misrepresent any fact in order to obtain workers' compensation insurance at less than the proper rate.

(2) Present or cause to be presented any knowingly false or fraudulent written or oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying any compensation, as defined in Section 3207.

(3) Knowingly solicit, receive, offer, pay, or accept any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for soliciting or referring clients or patients to obtain services or benefits pursuant to Division 4 (commencing with Section 3200) unless the payment or receipt of consideration for services other than the referral of clients or patients is lawful pursuant to Section 650 of the Business and Professions Code or expressly permitted by the Rules of Professional Conduct of the State Bar.

(4) Knowingly operate or participate in a service that, for profit, refers or recommends clients or patients to obtain medical or medical-legal services or benefits pursuant to Division 4 (commencing with Section 3200).

(5) Knowingly assist, abet, solicit, or conspire with any person who engages in an unlawful act under this section.

(c) For the purposes of this section, ''statement'' includes, but is not limited to, any notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-ray, test results, medical-legal expenses as defined in Section 4620, or other evidence of loss, expense, or payment.

(d) Any person who violates any provision of this section shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not less than four thousand dollars ($4,000) nor more than ten thousand dollars ($10,000), plus an assessment of not more than three times the amount of the medical treatment expenses paid pursuant to Article 2 (commencing with Section 4600) and medical-legal

expenses paid pursuant to Article 2.5 (commencing with Section 4620) for each claim for compensation submitted in violation of this section.

(e) Any person who violates subdivision (b) and who has a prior felony conviction of an offense set forth in Section 1871.1 or 1871.4 of the Insurance Code, or in Section 549 of the Penal Code, shall be subject, in addition to the penalties set forth in subdivision (d), to a civil penalty of four thousand dollars ($4,000) for each item or service with respect to which a violation of subdivision (b) occurred.

(f) The penalties provided for in subdivisions (d) and (e) shall be assessed and recovered in a civil action brought in the name of the people of the State of California by any district attorney.

(g) In assessing the amount of the civil penalty the court shall consider any one or more of the relevant circumstances presented by any of the parties to the case, including, but not limited to, the following: the nature and seriousness of the misconduct, the number of violations, the persistence of the misconduct, the length of time over which the misconduct occurred, the willfulness of the defendant's misconduct, and the defendant's assets, liabilities, and net worth.

(h) All penalties collected pursuant to this section shall be paid to the Workers' Compensation Fraud Account in the Insurance Fund pursuant to Section 1872.83 of the Insurance Code. All costs incurred by district attorneys in carrying out this article shall be funded from the Workers' Compensation Fraud Account. It is the intent of the Legislature that the program instituted by this article be supported entirely from funds produced by moneys deposited into the Workers' Compensation Fraud Account from the imposition of civil money penalties for workers' compensation fraud collected pursuant to this section. All moneys claimed by district attorneys as costs of carrying out this article shall be paid pursuant to a determination by the Fraud Assessment Commission established by Section 1872.83 of the Insurance Code and on appropriation by the Legislature.

SEC. 50. Section 3822 is added to the Labor Code, to read:

3822. The administrative director shall, on an annual basis, provide to every employer, claims adjuster, third party administrator, physician, and attorney who participates in the workers' compensation system, a notice that warns the recipient against committing workers' compensation fraud. The notice shall specify the penalties that are applied for committing workers' compensation fraud. The Fraud Assessment Commission, established by Section 1872.83 of the Insurance Code, shall provide the administrative director with all funds necessary to carry out this section.

SEC. 51. Section 4061 of the Labor Code is amended to read:

4061. (a) Together with the last payment of temporary disability indemnity, the employer shall, in a form prescribed by the administrative director pursuant to Section 138.4, provide the employee one of the following:

(1) Notice either that no permanent disability indemnity will be paid because the employer alleges the employee has no permanent impairment or limitations resulting from the injury or notice of the amount of permanent disability indemnity determined by the employer to be payable. The notice shall include information concerning how the employee may obtain a formal medical evaluation pursuant to subdivision (c) if he or she disagrees with the position taken by the employer. The notice shall be accompanied by the form prescribed by the Industrial Medical Council for requesting assignment of a panel of qualified medical evaluators, unless the employee is represented by an attorney. If the employer determines permanent disability indemnity is payable, the employer shall advise the employee of the amount determined payable and the basis on which the determination was made and whether there is need for continuing medical care.

(2) Notice that permanent disability indemnity may be or is payable, but that the amount cannot be determined because the employee's medical condition is not yet permanent and stationary. The notice shall advise the employee that his or her medical condition will be monitored until it is permanent and stationary, at which time the necessary evaluation will be performed to determine the existence and extent of permanent impairment and limitations for the purpose of rating permanent disability and to determine the need for continuing medical care, or at which time the employer will advise the employee of the amount of permanent disability indemnity the employer has determined to be payable. If an employee is provided notice pursuant to this paragraph and the employer later takes the position that the employee has no permanent impairment or limitations resulting from the injury, or later determines permanent disability indemnity is payable, the employer shall in either event, within 14 days of the determination to take either position, provide the employee with the notice specified in paragraph (1).

(b) Each notice required by subdivision (a) shall describe the administrative procedures available to the injured employee and advise the employee of his or her right to consult an information and assistance officer or an attorney. It shall contain the following language:

''Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by

an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.''

(c) If the parties do not agree to a permanent disability rating based on the treating physician's evaluation or the assessment of need for continuing medical care, and the employee is represented by an attorney, the employer shall seek agreement with the employee on a physician to prepare a comprehensive medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed to by the parties, the parties may not later select an agreed medical evaluator. Evaluations of an employee's permanent impairment and limitations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, either party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense.

(d) If the parties do not agree to a permanent disability rating based on the treating physician's evaluation, and if the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare an additional medical evaluation. The employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a medical evaluation of the employee's permanent impairment and limitations and any need for continuing medical care resulting from the injury.

For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the report of the qualified medical evaluator and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or the employer on the issues subject to this section.

(e) If an employee obtains a qualified medical evaluator from a panel pursuant to subdivision (d) or pursuant to subdivision (b) of Section 4062, and thereafter becomes represented by an attorney and obtains an additional qualified medical evaluator, the employer shall have a corresponding right to secure an additional qualified medical evaluator.

(f) The represented employee shall be responsible for making an appointment with an agreed medical evaluator.

(g) The unrepresented employee shall be responsible for making an appointment with a qualified medical evaluator selected from a panel of

three qualified medical evaluators. The evaluator shall give the employee, at the appointment, a brief opportunity to ask questions concerning the evaluation process and the evaluator's background. The unrepresented employee shall then participate in the evaluation as requested by the evaluator unless the employee has good cause to discontinue the evaluation. For purposes of this subdivision, ''good cause'' shall include evidence that the evaluator is biased against the employee because of his or her race, sex, national origin, religion, or sexual preference or evidence that the evaluator has requested the employee to submit to an unnecessary medical examination or procedure. If the unrepresented employee declines to proceed with the evaluation, he or she shall have the right to a new panel of three qualified medical evaluators from which to select one to prepare a comprehensive medical evaluation. If the appeals board subsequently determines that the employee did not have good cause to not proceed with the evaluation, the cost of the evaluation shall be deducted from any award the employee obtains.

(h) Upon selection or assignment pursuant to subdivision (c) or (d), the medical evaluator shall perform a comprehensive medical evaluation according to the procedures promulgated by the Industrial Medical Council under paragraphs (2) and (3) of subdivision (j) of Section 139.2 and summarize the medical findings on a form prescribed by the Industrial Medical Council. The comprehensive medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a comprehensive medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

(i) Except as provided in Section 139.3, the medical evaluator may obtain consultations from other physicians who have treated the employee for the injury whose expertise is necessary to provide a complete and accurate evaluation.

(j) The qualified medical evaluator who has evaluated an unrepresented employee shall serve the comprehensive medical evaluation and the summary form on the employee, employer, and the administrative director. The unrepresented employee or the employer may submit the treating physician's evaluation for the calculation of a permanent disability rating. Within 20 days of receipt of the comprehensive medical evaluation, the administrative director shall calculate the permanent disability rating according to Section 4660 and serve the rating on the employee and employer.

(k) Any comprehensive medical evaluation concerning an unrepresented employee which indicates that part or all of an employee's permanent impairment or limitations may be subject to apportionment pursuant to Sections 4663 or 4750 shall first be submitted by the administrative director to a workers' compensation judge who may refer the report back to the qualified medical evaluator for correction or clarification if the judge determines the proposed apportionment is inconsistent with the law.

(*l*) Within 30 days of receipt of the rating, if the employee is unrepresented, the employee or employer may request that the administrative director reconsider the recommended rating or obtain additional information from the treating physician or medical evaluator to address issues not addressed or not completely addressed in the original comprehensive medical evaluation or not prepared in accord with the procedures of the Industrial Medical Council promulgated under paragraph (2) or (3) of subdivision (j) of Section 139.2. This request shall be in writing, shall specify the reasons the rating should be reconsidered, and shall be served on the other party. If the administrative director finds the comprehensive medical evaluation is not complete or not in compliance with the required procedures, the administrative director shall return the report to the treating physician or qualified medical evaluator for appropriate action as the administrative director instructs. Upon receipt of the treating physician's or qualified medical evaluator's final comprehensive medical evaluation and summary form, the administrative director shall recalculate the permanent disability rating according to Section 4660 and serve the rating, the comprehensive medical evaluation, and the summary form on the employee and employer.

(m) If a comprehensive medical evaluation from the treating physician or an agreed medical evaluator or a qualified medical evaluator selected from a three-member panel resolves any issue so as to require an employer to provide compensation, the employer shall commence the payment of compensation or promptly commence proceedings before the appeals board to resolve the dispute. If the employee and employer agree to a stipulated findings and award as provided under Section 5702 or to compromise and release the claim under Chapter 2 (commencing with Section 5000) of Part 3, or if the employee wishes to commute the award under Chapter 3 (commencing with Section 5100) of Part 3, the appeals board shall first determine whether the agreement or commutation is in the best interests of the employee and whether the proper procedures have been followed in determining the permanent disability rating. The administrative director shall promulgate a form to notify the employee, at the time of service of

any rating under this section, of the options specified in this subdivision, the potential advantages and disadvantages of each option, and the procedure for disputing the rating.

(n) No issue relating to the existence or extent of permanent impairment and limitations or the need for continuing medical care resulting from the injury may be the subject of a declaration of readiness to proceed unless there has first been a medical evaluation by a treating physician or an agreed or qualified medical evaluator. With the exception of an evaluation or evaluations prepared by the treating physician or physicians, no evaluation of permanent impairment and limitations or need for continuing medical care resulting from the injury shall be obtained prior to service of the comprehensive medical evaluation on the employee and employer if the employee is unrepresented, or prior to the attempt to select an agreed medical evaluator if the employee is represented. Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the treating physician or physicians who treated the employee for the injury and comprehensive medical evaluations prepared by a qualified medical evaluator selected by an unrepresented employee from a three-member panel shall be admissible.

SEC. 52. Section 4062 of the Labor Code is amended to read:

4062. (a) If either the employee or employer objects to a medical determination made by the treating physician concerning the permanent and stationary status of the employee's medical condition, the employee's preclusion or likely preclusion to engage in his or her usual occupation, the extent and scope of medical treatment, the existence of new and further disability, or any other medical issues not covered by Section 4060 or 4061, the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. These time limits may be extended for good cause or by mutual agreement. If the employee is represented by an attorney, the parties shall seek agreement with the other party on a physician, who need not be a qualified medical evaluator, to prepare a report resolving the disputed issue. If no agreement is reached within 10 days, or any additional time not to exceed 20 days agreed upon by the parties, the parties may not later select an agreed medical evaluator. Evaluations obtained prior to the period to reach agreement shall not be admissible in any proceeding before the appeals board. After the period to reach agreement has expired, the objecting party may select a qualified medical evaluator to conduct the comprehensive medical evaluation. Neither party may obtain more than

one comprehensive medical-legal report, provided, however, that any party may obtain additional reports at their own expense. The nonobjecting party may continue to rely on the treating physician's report or may select a qualified medical evaluator to conduct an additional evaluation.

(b) If the employee is not represented by an attorney, the employer shall not seek agreement with the employee on a physician to prepare the comprehensive medical evaluation. The employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. The employee shall select a physician from the panel to prepare a comprehensive medical evaluation. For injuries occurring on or after January 1, 2003, except as provided in subdivision (b) of Section 4064, the evaluation of the qualified medical evaluator selected from a panel of three and the reports of the treating physician or physicians shall be the only admissible reports and shall be the only reports obtained by the employee or employer on issues subject to this section in a case involving an unrepresented employee.

(c) Upon completing a determination of the disputed medical issue, the physician selected under subdivision (a) or (b) to perform the medical evaluation shall summarize the medical findings on a form prescribed by the Industrial Medical Council and shall serve the formal medical evaluation and the summary form on the employee, employer, and administrative director. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator. If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

(d) No disputed medical issue specified in subdivision (a) may be the subject of a declaration of readiness to proceed unless there has first been an evaluation by the treating physician or an agreed or qualified medical evaluator.

(e) With the exception of a report or reports prepared by the treating physician or physicians, no report determining disputed medical issues set forth in subdivision (a) shall be obtained prior to the expiration of the period to reach agreement on the selection of an agreed medical evaluator under subdivision (a). Reports obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board. However, the testimony, records, and reports offered by the

treating physician or physicians who treated the employee for the injury shall be admissible.

SEC. 53. Section 4062.9 of the Labor Code is amended to read:

4062.9. (a) For injuries occurring on or after January 1, 2003, in cases where an additional comprehensive medical evaluation is obtained under Section 4061 or 4062, if the employee has been treated by his or her personal physician, or by his or her personal chiropractor, as defined in Section 4601, who was predesignated prior to the date of injury as provided under Section 4600, the findings of the personal physician or personal chiropractor are presumed to be correct. This presumption is rebuttable and may be controverted by a preponderance of medical opinion indicating a different level of disability. However, the presumption shall not apply where both parties select qualified medical examiners.

(b) The administrative director, in consultation with the Industrial Medical Council, shall develop, not later than January 1, 2004, and periodically revise as necessary thereafter, educational materials to be used to provide treating physicians and chiropractors with information and training in basic concepts of workers' compensation, the role of the treating physician, the conduct of permanent and stationary evaluations, and report writing.

SEC. 54. Section 4064 of the Labor Code is amended to read:

4064. (a) The employer shall be liable for the cost of each reasonable and necessary comprehensive medical-legal evaluation obtained by the employee pursuant to Sections 4060, 4061, and 4062. Each comprehensive medical-legal evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms.

(b) For injuries occurring on or after January 1, 2003, if an unrepresented employee obtains an attorney after the evaluation pursuant to subdivision (d) of Section 4061 or subdivision (b) of Section 4062 has been completed, the employee shall be entitled to the same reports at employer expense as an employee who has been represented from the time the dispute arose and those reports shall be admissible in any proceeding before the appeals board.

(c) Subject to Section 4906, if an employer files an application for adjudication and the employee is unrepresented at the time the application is filed, the employer shall be liable for any attorney's fees incurred by the employee in connection with the application for adjudication.

(d) The employer shall not be liable for the cost of any comprehensive medical evaluations obtained by the employee other than those authorized pursuant to Sections 4060, 4061, and 4062. However, no

party is prohibited from obtaining any medical evaluation or consultation at the party's own expense. In no event shall an employer or employee be liable for an evaluation obtained in violation of subdivision (b) of Section 4060. All comprehensive medical evaluations obtained by any party shall be admissible in any proceeding before the appeals board except as provided in subdivisions (d) and (m) of Section 4061 and subdivisions (b) and (e) of Section 4062.

SEC. 55. Section 4065 of the Labor Code is repealed.

SEC. 56. Section 4067 of the Labor Code is amended to read:

4067. If the jurisdiction of the appeals board is invoked pursuant to Section 5803 upon the grounds that the effects of the injury have recurred, increased, diminished, or terminated, a formal medical evaluation shall be obtained pursuant to this article.

When an agreed medical evaluator or a qualified medical evaluator selected by an unrepresented employee from a three-member panel has previously made a formal medical evaluation of the same or similar issues, the subsequent or additional formal medical evaluation shall be conducted by the same agreed medical evaluator or qualified medical evaluator, unless the workers' compensation judge has made a finding that he or she did not rely on the prior evaluator's formal medical evaluation, any party contested the original medical evaluation by filing an application for adjudication, the unrepresented employee hired an attorney and selected a qualified medical evaluator to conduct another evaluation pursuant to subdivision (b) of Section 4064, or the prior evaluator is no longer qualified or readily available to prepare a formal medical evaluation, in which case Sections 4061 or 4062, as the case may be, shall apply as if there had been no prior formal medical evaluation.

SEC. 57. Section 4453 of the Labor Code is amended to read:

4453. (a) In computing average annual earnings for the purposes of temporary disability indemnity and permanent total disability indemnity only, the average weekly earnings shall be taken at:

(1) Not less than one hundred twenty-six dollars ($126) nor more than two hundred ninety-four dollars ($294), for injuries occurring on or after January 1, 1983.

(2) Not less than one hundred sixty-eight dollars ($168) nor more than three hundred thirty-six dollars ($336), for injuries occurring on or after January 1, 1984.

(3) Not less than one hundred sixty-eight dollars ($168) for permanent total disability, and, for temporary disability, not less than the lesser of one hundred sixty-eight dollars ($168) or 1.5 times the employee's average weekly earnings from all employers, but in no event less than one hundred forty-seven dollars ($147), nor more than three

hundred ninety-nine dollars ($399), for injuries occurring on or after January 1, 1990.

(4) Not less than one hundred sixty-eight dollars ($168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars ($189) or 1.5 times the employee's average weekly earnings from all employers, nor more than five hundred four dollars ($504), for injuries occurring on or after January 1, 1991.

(5) Not less than one hundred sixty-eight dollars ($168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars ($189) or 1.5 times the employee's average weekly earnings from all employers, nor more than six hundred nine dollars ($609), for injuries occurring on or after July 1, 1994.

(6) Not less than one hundred sixty-eight dollars ($168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars ($189) or 1.5 times the employee's average weekly earnings from all employers, nor more than six hundred seventy-two dollars ($672), for injuries occurring on or after July 1, 1995.

(7) Not less than one hundred sixty-eight dollars ($168) for permanent total disability, and for temporary disability, not less than the lesser of one hundred eighty-nine dollars ($189) or 1.5 times the employee's average weekly earnings from all employers, nor more than seven hundred thirty-five dollars ($735), for injuries occurring on or after July 1, 1996.

(8) Not less than one hundred eighty-nine dollars ($189), nor more than nine hundred three dollars ($903) for injuries occurring on or after January 1, 2003.

(9) Not less than one hundred eighty-nine dollars ($189), nor more than one thousand ninety-two dollars ($1,092) for injuries occurring on or after January 1, 2004.

(10) Not less than one hundred eighty-nine dollars ($189), nor more than one thousand two hundred sixty dollars ($1,260) for injuries occurring on or after January 1, 2005. Commencing on January 1, 2006, and each January 1 thereafter, the limits specified in this paragraph shall be increased by an amount equal to the percentage increase in the state average weekly wage as compared to the prior year. For purposes of this paragraph, ''state average weekly wage'' means the average weekly wage paid by employers to employees covered by unemployment insurance as reported by the United States Department of Labor for California for the 12 months ending March 31 of the calendar year preceding the year in which the injury occurred.

(b) In computing average annual earnings for purposes of permanent partial disability indemnity, except as provided in Section 4659, the average weekly earnings shall be taken at:

(1) Not less than seventy-five dollars ($75), nor more than one hundred ninety-five dollars ($195), for injuries occurring on or after January 1, 1983.

(2) Not less than one hundred five dollars ($105), nor more than two hundred ten dollars ($210), for injuries occurring on or after January 1, 1984.

(3) When the final adjusted permanent disability rating of the injured employee is 15 percent or greater, but not more than 24.75 percent: (A) not less than one hundred five dollars ($105) nor more than two hundred twenty-two dollars ($222), for injuries occurring on or after July 1, 1994; (B) not less than one hundred five dollars ($105) nor more than two hundred thirty-one dollars ($231) for injuries occurring on or after July 1, 1995; (C) not less than one hundred five dollars ($105) nor more than two hundred forty dollars ($240) for injuries occurring on or after July 1, 1996.

(4) When the final adjusted permanent disability rating of the injured employee is 25 percent or greater, not less than one hundred five dollars ($105), nor more than two hundred twenty-two dollars ($222), for injuries occurring on or after January 1, 1991.

(5) When the final adjusted permanent disability rating of the injured employee is 25 percent or greater but not more than 69.75 percent: (A) not less than one hundred five dollars ($105), nor more than two hundred thirty-seven dollars ($237), for injuries occurring on or after July 1, 1994; (B) not less than one hundred five dollars ($105), nor more than two hundred forty-six dollars ($246), for injuries occurring on or after July 1, 1995; and (C) not less than one hundred five dollars ($105), nor more than two hundred fifty-five dollars ($255), for injuries occurring on and after July 1, 1996.

(6) When the final adjusted permanent disability rating of the injured employee is less than 70 percent: (A) not less than one hundred fifty dollars ($150), nor more than two hundred seventy-seven dollars and fifty cents ($277.50), for injuries occurring on or after January 1, 2003; (B) not less than one hundred fifty-seven dollars and fifty cents ($157.50), nor more than three hundred dollars ($300), for injuries occurring on or after January 1, 2004; (C) not less than one hundred fifty-seven dollars and fifty cents ($157.50), nor more than three hundred thirty dollars ($330) for injuries occurring on or after January 1, 2005; and (D) not less than one hundred ninety-five dollars ($195), nor more than three hundred forty-five dollars ($345), for injuries occurring on or after January 1, 2006.

(7) When the final adjusted permanent disability rating of the injured employee is 70 percent or greater, but less than 100 percent: (A) not less than one hundred five dollars ($105), nor more than two hundred fifty-two dollars ($252), for injuries occurring on or after July 1, 1994; (B) not less than one hundred five dollars ($105), nor more than two hundred ninety-seven dollars ($297), for injuries occurring on or after July 1, 1995; (C) not less than one hundred five dollars ($105), nor more than three hundred forty-five dollars ($345), for injuries occurring on or after July 1, 1996; (D) not less than one hundred fifty dollars ($150), nor more than three hundred forty-five dollars ($345), for injuries occurring on or after January 1, 2003; (E) not less than one hundred fifty-seven dollars and fifty cents ($157.50), nor more than three hundred seventy-five dollars ($375), for injuries occurring on or after January 1, 2004; (F) not less than one hundred fifty-seven dollars and fifty cents ($157.50), nor more than four hundred five dollars ($405) for injuries occurring on or after January 1, 2005; and (G) not less than one hundred ninety-five dollars ($195), nor more than four hundred five dollars ($405), for injuries occurring on or after January 1, 2006.

(c) Between the limits specified in subdivisions (a) and (b), the average weekly earnings, except as provided in Sections 4456 to 4459, shall be arrived at as follows:

(1) Where the employment is for 30 or more hours a week and for five or more working days a week, the average weekly earnings shall be the number of working days a week times the daily earnings at the time of the injury.

(2) Where the employee is working for two or more employers at or about the time of the injury, the average weekly earnings shall be taken as the aggregate of these earnings from all employments computed in terms of one week; but the earnings from employments other than the employment in which the injury occurred shall not be taken at a higher rate than the hourly rate paid at the time of the injury.

(3) If the earnings are at an irregular rate, such as piecework, or on a commission basis, or are specified to be by week, month, or other period, then the average weekly earnings mentioned in subdivision (a) shall be taken as the actual weekly earnings averaged for this period of time, not exceeding one year, as may conveniently be taken to determine an average weekly rate of pay.

(4) Where the employment is for less than 30 hours per week, or where for any reason the foregoing methods of arriving at the average weekly earnings cannot reasonably and fairly be applied, the average weekly earnings shall be taken at 100 percent of the sum which reasonably represents the average weekly earning capacity of the injured

employee at the time of his or her injury, due consideration being given to his or her actual earnings from all sources and employments.

(d) Every computation made pursuant to this section beginning January 1, 1990, shall be made only with reference to temporary disability or the permanent disability resulting from an original injury sustained after January 1, 1990. However, all rights existing under this section on January 1, 1990, shall be continued in force. Except as provided in Section 4661.5, disability indemnity benefits shall be calculated according to the limits in this section in effect on the date of injury and shall remain in effect for the duration of any disability resulting from the injury.

SEC. 58. Section 4455 of the Labor Code is amended to read:

4455. If the injured employee is under 18 years of age, and his or her incapacity is permanent, his or her average weekly earnings shall be deemed, within the limits fixed in Section 4453, to be the weekly sum that under ordinary circumstances he or she would probably be able to earn at the age of 18 years, in the occupation in which he or she was employed at the time of the injury or in any occupation to which he or she would reasonably have been promoted if he or she had not been injured. If the probable earnings at the age of 18 years cannot reasonably be determined, his or her average weekly earnings shall be taken at the maximum limit established in Section 4453.

SEC. 59. Section 4600.1 is added to the Labor Code, to read:

4600.1. Any pharmacy providing medicines and medical supplies required by Section 4600 shall provide the generic drug equivalent, if a generic drug equivalent is available, unless the prescribing physician specifically provides otherwise in writing.

SEC. 60. Section 4600.2 is added to the Labor Code, to read:

4600.2. (a) Notwithstanding Section 4600, when a self-insured employer, group of self-insured employers, insurer of an employer, or group of insurers contracts with a pharmacy, group of pharmacies, or pharmacy benefit network to provide medicines and medical supplies required by this article to be provided to injured employees, those injured employees that are subject to the contract shall be provided medicines and medical supplies in the manner prescribed in the contract for as long as medicines or medical supplies are reasonably required to cure or relieve the injured employee from the effects of the injury.

(b) Nothing in this section shall affect the ability of employee-selected physicians to continue to prescribe and have the employer provide medicines and medical supplies that the physicians deem reasonably required to cure or relieve the injured employee from the effects of the injury.

(c) Each contract described in subdivision (a) shall comply with standards adopted by the administrative director. In adopting those standards, the administrative director shall seek to reduce pharmaceutical costs and may consult any relevant studies or practices in other states. The standards shall provide for access to a pharmacy within a reasonable geographic distance from an injured employee's residence.

SEC. 61. Section 4600.3 of the Labor Code is amended to read:

4600.3. (a) (1) Notwithstanding Section 4600, when a self-insured employer, group of self-insured employers, or the insurer of an employer contracts with a health care organization certified pursuant to Section 4600.5 for health care services required by this article to be provided to injured employees, those employees who are subject to the contract shall receive medical services in the manner prescribed in the contract, providing that the employee may choose to be treated by a personal physician, personal chiropractor, or personal acupuncturist that he or she has designated prior to the injury, in which case the employee shall not be treated by the health care organization. Every employee shall be given an affirmative choice at the time of employment and at least annually thereafter to designate or change the designation of a health care organization or a personal physician, personal chiropractor, or personal acupuncturist. The choice shall be memorialized in writing and maintained in the employee's personnel records. The employee who has designated a personal physician, personal chiropractor, or personal acupuncturist may change their designated caregiver at any time prior to the injury. Any employee who fails to designate a personal physician, personal chiropractor, or personal acupuncturist shall be treated by the health care organization selected by the employer. If the health care organization offered by the employer is the workers' compensation insurer that covers the employee or is an entity that controls or is controlled by that insurer, as defined by Section 1215 of the Insurance Code, this information shall be included in the notice of contract with a health care organization.

(2) Each contract described in paragraph (1) shall comply with the certification standards provided in Section 4600.5, and shall provide all medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including artificial members, that is reasonably required to cure or relieve the effects of the injury, as required by this division, without any payment by the employee of deductibles, copayments, or any share of the premium. However, an employee may receive immediate emergency medical treatment that is compensable from a

medical service or health care provider who is not a member of the health care organization.

(3) Insured employers, a group of self-insured employers, or self-insured employers who contract with a health care organization for medical services shall give notice to employees of eligible medical service providers and any other information regarding the contract and manner of receiving medical services as the administrative director may prescribe. Employees shall be duly notified that if they choose to receive care from the health care organization they must receive treatment for all occupational injuries and illnesses as prescribed by this section.

(b) Notwithstanding subdivision (a), no employer which is required to bargain with an exclusive or certified bargaining agent which represents employees of the employer in accordance with state or federal employer-employee relations law shall contract with a health care organization for purposes of Section 4600.5 with regard to employees whom the bargaining agent is recognized or certified to represent for collective bargaining purposes pursuant to state or federal employer-employee relations law unless authorized to do so by mutual agreement between the bargaining agent and the employer. If the collective bargaining agreement is subject to the National Labor Relations Act, the employer may contract with a health care organization for purposes of Section 4600.5 at any time when the employer and bargaining agent have bargained to impasse to the extent required by federal law.

(c) (1) When an employee is not receiving or is not eligible to receive health care coverage for nonoccupational injuries or illnesses provided by the employer, if 90 days from the date the injury is reported the employee who has been receiving treatment from a health care organization or his or her physician, chiropractor, acupuncturist, or other agent notifies his or her employer in writing that he or she desires to stop treatment by the health care organization, he or she shall have the right to be treated by a physician, chiropractor, or acupuncturist or at a facility of his or her own choosing within a reasonable geographic area.

(2) When an employee is receiving or is eligible to receive health care coverage for nonoccupational injuries or illnesses provided by the employer, and has agreed to receive care for occupational injuries and illnesses from a health care organization provided by the employer, the employee may be treated for occupational injuries and diseases by a physician, chiropractor, or acupuncturist of his or her own choice or at a facility of his or her own choice within a reasonable geographic area if the employee or his or her physician, chiropractor, acupuncturist, or other agent notifies his or her employer in writing only after 180 days from the date the injury was reported, or upon the date of contract

renewal or open enrollment of the health care organization, whichever occurs first, but in no case until 90 days from the date the injury was reported.

(3) For purposes of this subdivision, an employer shall be deemed to provide health care coverage for nonoccupational injuries and illnesses if the employer pays more than one-half the costs of the coverage, or if the plan is established pursuant to collective bargaining.

(d) An employee and employer may agree to other forms of therapy pursuant to Section 3209.7.

(e) An employee enrolled in a health care organization shall have the right to no less than one change of physician on request, and shall be given a choice of physicians affiliated with the health care organization. The health care organization shall provide the employee a choice of participating physicians within five days of receiving a request. In addition, the employee shall have the right to a second opinion from a participating physician on a matter pertaining to diagnosis or treatment from a participating physician.

(f) Nothing in this section or Section 4600.5 shall be construed to prohibit a self-insured employer, a group of self-insured employers, or insurer from engaging in any activities permitted by Section 4600.

(g) Notwithstanding subdivision (c), in the event that the employer, group of employers, or the employer's workers' compensation insurer no longer contracts with the health care organization that has been treating an injured employee, the employee may continue treatment provided or arranged by the health care organization. If the employee does not choose to continue treatment by the health care organization, the employer may control the employee's treatment for 30 days from the date the injury was reported. After that period, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area.

SEC. 61.5. Section 4600.35 is added to the Labor Code, to read:

4600.35. Any entity seeking to reimburse health care providers for health care services rendered to injured workers on a capitated, or per person per month basis, shall be licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

SEC. 61.7. Section 4600.5 of the Labor Code is amended to read:

4600.5. (a) Any health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, a disability insurer licensed by the Department of Insurance, or any entity, including, but not limited to, workers' compensation insurers and third-party administrators authorized by the administrative director under subdivision (e), may make written application to the administrative director to become

certified as a health care organization to provide health care to injured employees for injuries and diseases compensable under this article.

(b) Each application for certification shall be accompanied by a reasonable fee prescribed by the administrative director, sufficient to cover the actual cost of processing the application. A certificate is valid for the period that the director may prescribe unless sooner revoked or suspended.

(c) If the health care organization is a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, that organization shall be deemed to be a health care organization able to provide health care pursuant to Section 4600.3 without further application. Those plans shall maintain good standing with the Department of Managed Health Care and meet the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Demonstrates the capability to provide occupational medicine and related disciplines.

(5) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(d) If the health care organization is a disability insurer licensed by the Department of Insurance, and is in compliance with subdivision (d) of Sections 10133 and 10133.5 of the Insurance Code, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that the plan is in good standing with the Department of Insurance and meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers' compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records prepared and submitted to the Department of Insurance in compliance with the Insurance Code relating to financial solvency, provider accessibility, peer review, utilization review, and quality assurance, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(e) If the health care organization is a workers' compensation insurer, third-party administrator, or any other entity that the administrative director determines meets the requirements of Section 4600.6, the administrative director shall certify the organization to provide health care pursuant to Section 4600.3 if the director finds that it meets the following additional requirements:

(1) Proposes to provide all medical and health care services that may be required by this article.

(2) Provides a program involving cooperative efforts by the employees, the employer, and the health plan to promote workplace health and safety, consultative and other services, and early return to work for injured employees.

(3) Proposes a timely and accurate method to meet the requirements set forth by the administrative director for all carriers of workers'

compensation coverage to report necessary information regarding medical and health care service cost and utilization, rates of return to work, average time in medical treatment, and other measures as determined by the administrative director to enable the director to determine the effectiveness of the plan.

(4) Agrees to provide the administrative director with information, reports, and records relating to provider accessibility, peer review, utilization review, quality assurance, advertising, disclosure, medical and financial audits, and grievance systems, upon request, if the administrative director determines the information is necessary to verify that the plan is providing medical treatment to injured employees consistent with the intent of this article.

Disclosure of peer review proceedings and records to the administrative director shall not alter the status of the proceedings or records as privileged and confidential communications pursuant to subdivision (d) of Section 10133 of the Insurance Code.

(5) Demonstrates the capability to provide occupational medicine and related disciplines.

(6) Complies with any other requirement the administrative director determines is necessary to provide medical services to injured employees consistent with the intent of this article, including, but not limited to, a written patient grievance policy.

(7) Complies with the following requirements:

(A) An organization certified by the administrative director under this subdivision may not provide or undertake to arrange for the provision of health care to employees, or to pay for or to reimburse any part of the cost of that health care in return for a prepaid or periodic charge paid by or on behalf of those employees.

(B) Every organization certified under this subdivision shall operate on a fee-for-service basis. As used in this section, fee for service refers to the situation where the amount of reimbursement paid by the employer to the organization or providers of health care is determined by the amount and type of health care rendered by the organization or provider of health care.

(C) An organization certified under this subdivision is prohibited from assuming risk.

(f) (1) A workers' compensation health care provider organization authorized by the Department of Corporations on December 31, 1997, shall be eligible for certification as a health care organization under subdivision (e).

(2) An entity that had, on December 31, 1997, submitted an application with the Commissioner of Corporations under Part 3.2 (commencing with Section 5150) shall be considered an applicant for

certification under subdivision (e) and shall be entitled to priority in consideration of its application. The Commissioner of Corporations shall provide complete files for all pending applications to the administrative director on or before January 31, 1998.

(g) The provisions of this section shall not affect the confidentiality or admission in evidence of a claimant's medical treatment records.

(h) Charges for services arranged for or provided by health care service plans certified by this section and that are paid on a per-enrollee-periodic-charge basis shall not be subject to the schedules adopted by the administrative director pursuant to Section 5307.1.

(i) Nothing in this section shall be construed to expand or constrict any requirements imposed by law on a health care service plan or insurer when operating as other than a health care organization pursuant to this section.

(j) In consultation with interested parties, including the Department of Corporations and the Department of Insurance, the administrative director shall adopt rules necessary to carry out this section.

(k) The administrative director shall refuse to certify or may revoke or suspend the certification of any health care organization under this section if the director finds that:

(1) The plan for providing medical treatment fails to meet the requirements of this section.

(2) A health care service plan licensed by the Department of Managed Health Care, a workers' compensation health care provider organization authorized by the Department of Corporations, or a carrier licensed by the Department of Insurance is not in good standing with its licensing agency.

(3) Services under the plan are not being provided in accordance with the terms of a certified plan.

(*l*) (1) When an injured employee requests chiropractic treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of a chiropractor pursuant to guidelines for chiropractic care established by paragraph (2). Within five working days of the employee's request to see a chiropractor, the health care organization and any person or entity who directs the kind or manner of health care services for the plan shall refer an injured employee to an affiliated chiropractor for work-related injuries that are within the guidelines for chiropractic care established by paragraph (2). Chiropractic care rendered in accordance with guidelines for chiropractic care established pursuant to paragraph (2) shall be provided by duly licensed chiropractors affiliated with the plan.

(2) The health care organization shall establish guidelines for chiropractic care in consultation with affiliated chiropractors who are

participants in the health care organization's utilization review process for chiropractic care, which may include qualified medical evaluators knowledgeable in the treatment of chiropractic conditions. The guidelines for chiropractic care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated chiropractor for the evaluation or treatment, or both, of neuromusculoskeletal conditions.

(3) Whenever a dispute concerning the appropriateness or necessity of chiropractic care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for chiropractic care in accordance with the health care organization's guidelines for chiropractic care established by paragraph (2).

Chiropractic utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for chiropractic care. Chiropractors affiliated with the plan shall have access to the health care organization's provider appeals process and, in the case of chiropractic care for work-related injuries, the review shall include review by a chiropractor affiliated with the health care organization, as determined by the health care organization.

(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to chiropractic care, including the location and telephone number where grievances may be submitted.

(5) All guidelines for chiropractic care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.

(m) Individually identifiable medical information on patients submitted to the division shall not be subject to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(n) (1) When an injured employee requests acupuncture treatment for work-related injuries, the health care organization shall provide the injured worker with access to the services of an acupuncturist pursuant to guidelines for acupuncture care established by paragraph (2). Within five working days of the employee's request to see an acupuncturist, the health care organization and any person or entity who directs the kind or manner of health care services for the plan shall refer an injured employee to an affiliated acupuncturist for work-related injuries that are within the guidelines for acupuncture care established by paragraph (2). Acupuncture care rendered in accordance with guidelines for acupuncture care established pursuant to paragraph (2) shall be provided by duly licensed acupuncturists affiliated with the plan.

(2) The health care organization shall establish guidelines for acupuncture care in consultation with affiliated acupuncturists who are participants in the health care organization's utilization review process for acupuncture care, which may include qualified medical evaluators. The guidelines for acupuncture care shall, at a minimum, explicitly require the referral of any injured employee who so requests to an affiliated acupuncturist for the evaluation or treatment, or both, of neuromusculoskeletal conditions.

(3) Whenever a dispute concerning the appropriateness or necessity of acupuncture care for work-related injuries arises, the dispute shall be resolved by the health care organization's utilization review process for acupuncture care in accordance with the health care organization's guidelines for acupuncture care established by paragraph (2).

Acupuncture utilization review for work-related injuries shall be conducted in accordance with the health care organization's approved quality assurance standards and utilization review process for acupuncture care. Acupuncturists affiliated with the plan shall have access to the health care organization's provider appeals process and, in the case of acupuncture care for work-related injuries, the review shall include review by an acupuncturist affiliated with the health care organization, as determined by the health care organization.

(4) The health care organization shall inform employees of the procedures for processing and resolving grievances, including those related to acupuncture care, including the location and telephone number where grievances may be submitted.

(5) All guidelines for acupuncture care and utilization review shall be consistent with the standards of this code that require care to cure or relieve the effects of the industrial injury.

SEC. 62. Section 4603.4 is added to the Labor Code, to read:

4603.4. (a) The administrative director shall adopt rules and regulations to do all of the following:

(1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms.

(2) Require acceptance by employers of electronic claims for payment of medical services.

(3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services.

(b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996.

SEC. 62.5. Section 4628 of the Labor Code is amended to read:

4628. (a) Except as provided in subdivision (c), no person, other than the physician who signs the medical-legal report, except a nurse

performing those functions routinely performed by a nurse, such as taking blood pressure, shall examine the injured employee or participate in the nonclerical preparation of the report, including all of the following:

(1) Taking a complete history.

(2) Reviewing and summarizing prior medical records.

(3) Composing and drafting the conclusions of the report.

(b) The report shall disclose the date when and location where the evaluation was performed; that the physician or physicians signing the report actually performed the evaluation; whether the evaluation performed and the time spent performing the evaluation was in compliance with the guidelines established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 and shall disclose the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than its clerical preparation. If the report discloses that the evaluation performed or the time spent performing the evaluation was not in compliance with the guidelines established by the Industrial Medical Council or the administrative director, the report shall explain, in detail, any variance and the reason or reasons therefor.

(c) If the initial outline of a patient's history or excerpting of prior medical records is not done by the physician, the physician shall review the excerpts and the entire outline and shall make additional inquiries and examinations as are necessary and appropriate to identify and determine the relevant medical issues.

(d) No amount may be charged in excess of the direct charges for the physician's professional services and the reasonable costs of laboratory examinations, diagnostic studies, and other medical tests, and reasonable costs of clerical expense necessary to producing the report. Direct charges for the physician's professional services shall include reasonable overhead expense.

(e) Failure to comply with the requirements of this section shall make the report inadmissible as evidence and shall eliminate any liability for payment of any medical-legal expense incurred in connection with the report.

(f) Knowing failure to comply with the requirements of this section shall subject the physician to a civil penalty of up to one thousand dollars ($1,000) for each violation to be assessed by a workers' compensation judge or the appeals board. All civil penalties collected under this section shall be deposited in the Workers' Compensation Administration Revolving Fund.

(g) A physician who is assessed a civil penalty under this section may be terminated, suspended, or placed on probation as a qualified medical evaluator pursuant to subdivisions (k) and (*l*) of Section 139.2.

(h) Knowing failure to comply with the requirements of this section shall subject the physician to contempt pursuant to the judicial powers vested in the appeals board.

(i) Any person billing for medical-legal evaluations, diagnostic procedures, or diagnostic services performed by persons other than those employed by the reporting physician or physicians, or a medical corporation owned by the reporting physician or physicians shall specify the amount paid or to be paid to those persons for the evaluations, procedures, or services. This subdivision shall not apply to any procedure or service defined or valued pursuant to Section 5307.1.

(j) The report shall contain a declaration by the physician signing the report, under penalty of perjury, stating:

''I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.''

The foregoing declaration shall be dated and signed by the reporting physician and shall indicate the county wherein it was signed.

(k) The physician shall provide a curriculum vitae upon request by a party and include a statement concerning the percent of the physician's total practice time that is annually devoted to medical treatment.

SEC. 63. Section 4644 of the Labor Code is amended to read:

4644. (a) The liability of the employer for vocational rehabilitation services shall terminate when any of the following events occur:

(1) An employee who has received notice of potential eligibility to participate in a rehabilitation plan under Section 4637 declines vocational rehabilitation services in the form and manner prescribed by the administrative director.

(2) A qualified injured worker completes a vocational rehabilitation plan except as otherwise provided in subdivisions (c) and (d).

(3) The qualified injured worker unreasonably failed to complete a vocational rehabilitation plan.

(4) An employee has not requested vocational rehabilitation services within 90 days of the notification that the employee is medically eligible for vocational rehabilitation services. The liability of the employer for vocational rehabilitation services shall not terminate under this paragraph unless the employer, not earlier than 45 days nor later than 70 days after the employee's receipt of the notice required by Section 4637,

reminds the employee of his or her right to vocational rehabilitation services or until the 21st day after the employee receives the reminder notification. The reminder notification shall be in writing, in the form and manner prescribed by the administrative director, and shall be served by certified mail. The provisions of this paragraph shall not apply if the employee shows he or she was unable to comprehend the consequences of failing to timely request vocational rehabilitation services, or that, because of conditions beyond the control of the employee, the employee was unable to exercise his or her right to accept or decline vocational rehabilitation services.

(5) The employer offers, and the employee accepts or rejects, in the form and manner prescribed by the administrative director, modified work lasting at least 12 months, provided that an employer who offers modified work that is available for the 12-month period required by this paragraph meets the requirements of this paragraph even if the employee voluntarily quits prior to the end of that 12-month period.

(6) The employer offers and the employee accepts or rejects, in the form and manner prescribed by the administrative director, alternative work meeting all of the following conditions:

(A) The employee has the ability to perform the essential functions of the job provided.

(B) The job provided is in a regular position lasting at least 12 months. An employer who offers alternative work that is available for the 12-month period required by this paragraph meets the requirements of this paragraph even if the employee voluntarily quits prior to the end of the 12-month period.

(C) The job provided offers wages and compensation that are within 15 percent of those paid to the employee at the time of injury.

(D) The job is located within reasonable commuting distance of the employee's residence at the time of injury.

(7) The employer offers, and the employee accepts, in the form and manner prescribed by the administrative director, work not meeting the conditions of paragraph (5) or (6) provided that the work lasts at least 12 months. The employee shall be required to reject the offer, in the form and manner prescribed by the administrative director, in order for the employee to be eligible for vocational rehabilitation services. An employer who offers work that is available for the 12-month period meets the requirements of this paragraph, even if the employee voluntarily quits prior to the end of that 12-month period.

(8) The employee and employer have agreed to self-directed vocational rehabilitation that is approved as set forth in Section 4646.

(b) Nothing in this article shall preclude the deferral or interruption of vocational rehabilitation services upon agreement of the employee

and employer or, if no agreement can be reached, upon a good cause determination by the administrative director.

(c) (1) Except as provided in this section, vocational rehabilitation plans prepared pursuant to Section 4638 shall be limited to one plan per injured worker. The plans shall be completed within an 18-month period after approval of the plan. The plan shall not include a period of job placement exceeding 60 days unless the plan is exclusively utilizing transferable skills and experience for direct placement activities. In these cases, the period of job placement may be up to 90 days.

(2) The employee shall be entitled to one additional vocational rehabilitation plan only if the original plan is determined to be inappropriate due to one of the following:

(A) The employee's disability has deteriorated to the point where the worker is unable to meet the physical demands of the first plan.

(B) The first plan is disrupted due to circumstances beyond the control of the employee.

(C) Failure by the employer to provide timely service required by this article and the vocational rehabilitation plan when the plan has not been completed.

The cost of the original and the additional plan plus all other vocational rehabilitation costs shall not exceed the overall cap and the counselor fee cap established in subdivision (c) of Section 139.5.

(d) Notwithstanding subdivision (c), an employee may apply to the rehabilitation unit for approval of a second vocational rehabilitation plan which exceeds the overall cap provided for in subdivision (c) of Section 139.5 if all of the following conditions are met:

(1) The employee has a permanent disability rating of 25 percent or greater. In reaching this determination, the rehabilitation unit shall consider any treating physicians' reports.

(2) The first plan cannot be completed due to circumstances beyond the control of the employee. Those circumstances include the deterioration of the employee's disability to the point where the worker cannot meet the requirements of the first plan.

(3) The rehabilitation unit finds that a second plan is necessary to provide the employee the opportunity for suitable gainful employment. Approval for circumstances other than a change in the employee's disability must be based on objective and verifiable facts pursuant to rules promulgated by the administrative director.

However, in no case shall the cost solely attributable to the second plan exceed the overall cap and the counseling fee cap contained in subdivision (c) of Section 139.5.

(e) Notwithstanding subdivision (c), an employee may receive a second vocational rehabilitation plan that exceeds the overall cap

provided for in subdivision (c) of Section 139.5 if the rehabilitation unit finds that the employee cannot complete the plan because the school or other training facility has closed or the worker has a sudden and unexpected change in disability that renders the plan inappropriate or other similar circumstances.

(f) Notwithstanding paragraph (2) of subdivision (a), if a qualified injured worker returns to modified or alternative work with the same employer or to work with a different employer as a result of direct job placement assistance and that employment terminates, other than for cause, within 12 months of the date the employee was employed at the modified or alternative work, and if that work is unavailable in the labor market, the employer shall be liable, subject to Section 4642, for additional vocational rehabilitation services, provided that the employer's liability for vocational rehabilitation services shall terminate if the employee voluntarily quits prior to the end of that 12-month period. To qualify for additional vocational rehabilitation services, the employee shall demonstrate an inability to compete for suitable gainful employment with his or her existing skills.

(g) An employer shall not be liable to provide vocational rehabilitation services at a location outside the state, unless upon agreement of the employer and the employee, or a determination by the Division of Workers' Compensation that those services are more cost effective than similar services provided in the state.

SEC. 64. Section 4646 of the Labor Code is amended to read:

4646. (a) Settlement or commutation of prospective vocational rehabilitation services shall not be permitted under Chapter 2 (commencing with Section 5000) or Chapter 3 (commencing with Section 5100) of Part 3 except as set forth in subdivision (b), or upon a finding by a workers' compensation judge that there are good faith issues that, if resolved against the employee, would defeat the employee's right to all compensation under this division.

(b) The employer and a represented employee may agree to settle the employee's right to prospective vocational rehabilitation services with a one-time payment to the employee not to exceed ten thousand dollars ($10,000) for the employee's use in self-directed vocational rehabilitation. The settlement agreement shall be submitted to, and approved by, the administrative director's vocational rehabilitation unit upon a finding that the employee has knowingly and voluntarily agreed to relinquish his or her rehabilitation rights. The rehabilitation unit may only disapprove the settlement agreement upon a finding that receipt of rehabilitation services is necessary to return the employee to suitable gainful employment.

(c) Prior to entering into any settlement agreement pursuant to this section, the attorney for a represented employee shall fully disclose and explain to the employee the nature and quality of the rights and privileges being waived.

SEC. 65. Section 4651 of the Labor Code is amended to read:

4651. (a) No disability indemnity payment shall be made by any written instrument unless it is immediately negotiable and payable in cash, on demand, without discount at some established place of business in the state.

Nothing in this section shall prohibit an employer from depositing the disability indemnity payment in an account in any bank, savings and loan association or credit union of the employee's choice in this state, provided the employee has voluntarily authorized the deposit, nor shall it prohibit an employer from electronically depositing the disability indemnity payment in an account in any bank, savings and loan association, or credit union, that the employee has previously authorized to receive electronic deposits of payroll, unless the employee has requested, in writing, that disability indemnity benefits not be electronically deposited in the account.

(b) It is not a violation of this section if a delay in the negotiation of a written instrument is caused solely by the application of state or federal banking laws or regulations.

(c) On or before July 1, 2004, the administrative director shall present to the Governor recommendations on how to provide better access to funds paid to injured workers in light of the requirements of federal and state laws and regulations governing the negotiability of disability indemnity payments. The administrative director shall make specific recommendations regarding payments to migratory and seasonal farmworkers. The Commission on Health and Safety and Workers' Compensation and the Employment Development Department shall assist the administrative director in the completion of this report.

SEC. 66. Section 4658 of the Labor Code is amended to read:

4658. (a) For injuries occurring prior to January 1, 1992, if the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the disability payment computed and allowed, according to paragraph (1). However, in no event shall the disability payment allowed be less than the disability payment computed according to paragraph (2).

(1)

Column 1—Range of percentage of permanent disability incurred:	Column 2—Number of weeks for which two–thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
Under 10	3
10–19.75	4
20–29.75	5
30–49.75	6
50–69.75	7
70–99.75	8

The number of weeks for which payments shall be allowed set forth in column 2 above based upon the percentage of permanent disability set forth in column 1 above shall be cumulative, and the number of benefit weeks shall increase with the severity of the disability. The following schedule is illustrative of the computation of the number of benefit weeks:

Column 1—Percentage of permanent disability incurred:	Column 2—Cumulative number of benefit weeks:
5	15.00
10	30.25
15	50.25
20	70.50
25	95.50
30	120.75
35	150.75
40	180.75
45	210.75
50	241.00
55	276.00
60	311.00
65	346.00
70	381.25
75	421.25

80	461.25
85	501.25
90	541.25
95	581.25
100	for life

(2) Two-thirds of the average weekly earnings for four weeks for each 1 percent of disability, where, for the purposes of this subdivision, the average weekly earnings shall be taken at not more than seventy-eight dollars and seventy-five cents ($78.75).

(b) This subdivision shall apply to injuries occurring on or after January 1, 1992. If the injury causes permanent disability, the percentage of disability to total disability shall be determined, and the disability payment computed and allowed, according to paragraph (1). However, in no event shall the disability payment allowed be less than the disability payment computed according to paragraph (2).

(1)

Column 1—Range of percentage of permanent disability incurred:	Column 2—Number of weeks for which two–thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
Under 10	3
10–19.75	4
20–24.75	5
25–29.75	6
30–49.75	7
50–69.75	8
70–99.75	9

The numbers set forth in column 2 above are based upon the percentage of permanent disability set forth in column 1 above and shall be cumulative, and shall increase with the severity of the disability in the manner illustrated in subdivision (a).

(2) Two-thirds of the average weekly earnings for four weeks for each 1 percent of disability, where, for the purposes of this subdivision, the average weekly earnings shall be taken at not more than seventy-eight dollars and seventy-five cents ($78.75).

(c) This subdivision shall apply to injuries occurring on or after January 1, 2004. If the injury causes permanent disability, the percentage

of disability to total disability shall be determined, and the disability payment computed and allowed as follows:

Column 1—Range of percentage of permanent disability incurred:	Column 2—Number of weeks for which two–thirds of average weekly earnings allowed for each 1 percent of permanent disability within percentage range:
Under 10	4
10–19.75	5
20–24.75	5
25–29.75	6
30–49.75	7
50–69.75	8
70–99.75	9

The numbers set forth in column 2 above are based upon the percentage of permanent disability set forth in column 1 above and shall be cumulative, and shall increase with the severity of the disability in the manner illustrated in subdivision (a).

SEC. 67. Section 4659 of the Labor Code is amended to read:

4659. (a) If the permanent disability is at least 70 percent, but less than 100 percent, 1.5 percent of the average weekly earnings for each 1 percent of disability in excess of 60 percent is to be paid during the remainder of life, after payment for the maximum number of weeks specified in Section 4658 has been made. For the purposes of this subdivision only, average weekly earnings shall be taken at not more than one hundred seven dollars and sixty-nine cents ($107.69). For injuries occurring on or after July 1, 1994, average weekly wages shall not be taken at more than one hundred fifty-seven dollars and sixty-nine cents ($157.69). For injuries occurring on or after July 1, 1995, average weekly wages shall not be taken at more than two hundred seven dollars and sixty-nine cents ($207.69). For injuries occurring on or after July 1, 1996, average weekly wages shall not be taken at more than two hundred fifty-seven dollars and sixty-nine cents ($257.69). For injuries occurring on or after January 1, 2006, average weekly wages shall not be taken at more than five hundred fifteen dollars and thirty-eight cents ($515.38).

(b) If the permanent disability is total, the indemnity based upon the average weekly earnings determined under Section 4453 shall be paid during the remainder of life.

(c) For injuries occurring on or after January 1, 2003, an employee who becomes entitled to receive a life pension or total permanent disability indemnity as set forth in subdivisions (a) and (b) shall have that payment increased annually commencing on January 1, 2004, and each January 1 thereafter, by an amount equal to the percentage increase in the ''state average weekly wage'' as compared to the prior year. For purposes of this subdivision, ''state average weekly wage'' means the average weekly wage paid by employers to employees covered by unemployment insurance as reported by the United States Department of Labor for California for the 12 months ending March 31 of the calendar year preceding the year in which the injury occurred.

SEC. 68. Section 4702 of the Labor Code is amended to read:

4702. (a) Except as otherwise provided in this section and Sections 4553, 4554, 4557, and 4558, the death benefit in cases of total dependency shall be as follows:

(1) In the case of two total dependents and regardless of the number of partial dependents, for injuries occurring before January 1, 1991, ninety-five thousand dollars ($95,000), for injuries occurring on or after January 1, 1991, one hundred fifteen thousand dollars ($115,000), for injuries occurring on or after July 1, 1994, one hundred thirty-five thousand dollars ($135,000), for injuries occurring on or after July 1, 1996, one hundred forty-five thousand dollars ($145,000), and for injuries occurring on or after January 1, 2006, two hundred ninety thousand dollars ($290,000).

(2) In the case of one total dependent and one or more partial dependents, for injuries occurring before January 1, 1991, seventy thousand dollars ($70,000), for injuries occurring on or after January 1, 1991, ninety-five thousand dollars ($95,000), for injuries occurring on or after July 1, 1994, one hundred fifteen thousand dollars ($115,000), for injuries occurring on or after July 1, 1996, one hundred twenty-five thousand dollars ($125,000), and for injuries occurring on or after January 1, 2006, two hundred fifty thousand dollars ($250,000), plus four times the amount annually devoted to the support of the partial dependents, but not more than the following: for injuries occurring before January 1, 1991, a total of ninety-five thousand dollars ($95,000), for injuries occurring on or after January 1, 1991, one hundred fifteen thousand dollars ($115,000), for injuries occurring on or after July 1, 1994, one hundred twenty-five thousand dollars ($125,000), for injuries occurring on or after July 1, 1996, one hundred forty-five thousand dollars ($145,000), and for injuries occurring on or after January 1, 2006, two hundred ninety thousand dollars ($290,000).

(3) In the case of one total dependent and no partial dependents, for injuries occurring before January 1, 1991, seventy thousand dollars

($70,000), for injuries occurring on or after January 1, 1991, ninety-five thousand dollars ($95,000), for injuries occurring on or after July 1, 1994, one hundred fifteen thousand dollars ($115,000), for injuries occurring on or after July 1, 1996, one hundred twenty-five thousand dollars ($125,000), and for injuries occurring on or after January 1, 2006, two hundred fifty thousand dollars ($250,000).

(4) (A) In the case of no total dependents and one or more partial dependents, for injuries occurring before January 1, 1991, four times the amount annually devoted to the support of the partial dependents, but not more than seventy thousand dollars ($70,000), for injuries occurring on or after January 1, 1991, a total of ninety-five thousand dollars ($95,000), for injuries occurring on or after July 1, 1994, one hundred fifteen thousand dollars ($115,000), and for injuries occurring on or after July 1, 1996, but before January 1, 2006, one hundred twenty-five thousand dollars ($125,000).

(B) In the case of no total dependents and one or more partial dependents, eight times the amount annually devoted to the support of the partial dependents, for injuries occurring on or after January 1, 2006, but not more than two hundred fifty thousand dollars ($250,000).

(5) In the case of three or more total dependents and regardless of the number of partial dependents, one hundred fifty thousand dollars ($150,000), for injuries occurring on or after July 1, 1994, one hundred sixty thousand dollars ($160,000), for injuries occurring on or after July 1, 1996, and three hundred twenty thousand dollars ($320,000), for injuries occurring on or after January 1, 2006.

(6) In the case of no total dependents and no partial dependents, two hundred fifty thousand dollars ($250,000) to the estate of the deceased employee.

(b) The death benefit in all cases shall be paid in installments in the same manner and amounts as temporary total disability indemnity would have to be made to the employee, unless the appeals board otherwise orders. However, no payment shall be made at a weekly rate of less than two hundred twenty-four dollars ($224).

(c) Disability indemnity shall not be deducted from the death benefit and shall be paid in addition to the death benefit when the injury resulting in death occurs after September 30, 1949.

(d) All rights under this section existing prior to January 1, 1990, shall be continued in force.

SEC. 69. Section 4703.5 of the Labor Code is amended to read:

4703.5. In the case of one or more totally dependent minor children, as defined in Section 3501, after payment of the amount specified in Section 4702, and notwithstanding the maximum limitations specified in Sections 4702 and 4703, payment of death benefits shall continue

until the youngest child attains age 18, or until the death of a child physically or mentally incapacitated from earning, in the same manner and amount as temporary total disability indemnity would have been paid to the employee, except that no payment shall be made at a weekly rate of less than two hundred twenty-four dollars ($224).

SEC. 70. Section 4903.5 is added to the Labor Code, to read:

4903.5. (a) No lien claim for expenses as provided in subdivision (b) of Section 4903 may be filed after six months from the date on which the appeals board or a workers' compensation administrative law judge issues a final decision, findings, order, including an order approving compromise and release, or award, on the merits of the claim, after five years from the date of the injury for which the services were provided, or after one year from the date the services were provided, whichever is later.

(b) Notwithstanding subdivision (a), any health care provider, health care service plan, group disability insurer, employee benefit plan, or other entity providing medical benefits on a nonindustrial basis, may file a lien claim for expenses as provided in subdivision (b) of Section 4903 within six months after the person or entity first has knowledge that an industrial injury is being claimed.

(c) The injured worker shall not be liable for any underlying obligation if a lien claim has not been filed and served within the allowable period. Except when the lien claimant is the applicant as provided in Section 5501, a lien claimant shall not file a declaration of readiness to proceed in any case until the case-in-chief has been resolved.

(d) This section shall not apply to civil actions brought under the Cartwright Act (Chapter 2 (commencing with Section 16700) of Part 2 of Division 7 of the Business and Professions Code), the Unfair Practices Act (Chapter 4 (commencing with Section 17000) of Part 2 of Division 7 of the Business and Professions Code), or the federal Racketeer Influenced and Corrupt Organization Act (Chapter 96 (commencing with Section 1961) of Title 18 of the United States Code) based on concerted action with other insurers that are not parties to the case in which the lien or claim is filed.

SEC. 70.5. Section 5275 of the Labor Code is amended to read:

5275. (a) Disputes involving the following issues shall be submitted for arbitration:

(1) Insurance coverage.

(2) Right of contribution in accordance with Section 5500.5.

(b) By agreement of the parties, any issue arising under Division 1 (commencing with Section 50) or Division 4 (commencing with Section 3200) may be submitted for arbitration, regardless of the date of injury.

SEC. 71. Section 5305 of the Labor Code is amended to read:

5305. The Division of Workers' Compensation, including the administrative director, and the appeals board have jurisdiction over all controversies arising out of injuries suffered outside the territorial limits of this state in those cases where the injured employee is a resident of this state at the time of the injury and the contract of hire was made in this state. Any employee described by this section, or his or her dependents, shall be entitled to the compensation or death benefits provided by this division.

SEC. 72. Section 5307 of the Labor Code is amended to read:

5307. (a) Except for those rules and regulations within the authority of the court administrator regarding trial level proceedings as defined in subdivision (c), the appeals board may by an order signed by four members:

(1) Adopt reasonable and proper rules of practice and procedure.

(2) Regulate and provide the manner in which, and by whom, minors and incompetent persons are to appear and be represented before it.

(3) Regulate and prescribe the kind and character of notices, where not specifically prescribed by this division, and the service thereof.

(4) Regulate and prescribe the nature and extent of the proofs and evidence.

(b) No rule or regulation of the appeals board pursuant to this section shall be adopted, amended, or rescinded without public hearings. Any written request filed with the appeals board seeking a change in its rules or regulations shall be deemed to be denied if not set by the appeals board for public hearing to be held within six months of the date on which the request is received by the appeals board.

(c) The court administrator shall adopt reasonable, proper, and uniform rules for district office procedure regarding trial level proceedings of the workers' compensation appeals board. These rules shall include, but not be limited to, all of the following:

(1) Rules regarding conferences, hearings, continuances, and other matters deemed reasonable and necessary to expeditiously resolve disputes.

(2) The kind and character of forms to be used at all trial level proceedings.

All rules and regulations adopted by the court administrator pursuant to this subdivision shall be subject to the requirements of the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 73. Section 5307.2 is added to the Labor Code, to read:

5307.2. The administrative director, after public hearings, shall adopt, not later than July 1, 2003, and revise, no less frequently than

biennially, an official pharmaceutical fee schedule that shall establish reasonable maximum fees paid for medicines and medical supplies provided pursuant to this division. This schedule shall be included within the official medical fee schedule adopted by the administrative director pursuant to Section 5307.1. In adopting the reasonable maximum fees included within the official pharmaceutical fee schedule, the administrative director may consult any relevant studies or practices in other states or in other payment systems in California. The schedule shall include a single dispensing fee. The schedule shall provide for access to a pharmacy within a reasonable geographic distance from an injured employee's residence.

SEC. 74. Section 5307.21 is added to the Labor Code, to read:

5307.21. (a) The administrative director shall have the sole authority to develop an outpatient surgery facility fee schedule for services not performed under contract, provided that the schedule meets all of the following requirements:

(1) The schedule shall include all facility charges for outpatient surgeries performed in any facility authorized by law to perform the surgeries. The schedule may not include the fee of any physician and surgeon providing services in connection with the surgery.

(2) The schedule shall promote payment predictability, minimize administrative costs, and ensure access to outpatient surgery services by insured workers.

(3) The schedule shall be sufficient to cover the costs of each surgical procedure, as well as access to quality care.

(4) The schedule shall include specific provisions for review and revision of related fees no less frequently then biennially.

(5) The schedule shall be adopted after public hearings pursuant to Section 5307.3 and shall be included within the official medical fee schedule.

(b) The process used by the administrative director to develop an outpatient surgery fee schedule shall contain the following elements:

(1) A formal analysis of one year of published data collected pursuant to Section 128737 of the Health and Safety Code, with the assistance of an independent consultant with demonstrated expertise in outpatient surgery service.

(2) Any published data collected from providers of outpatient surgery services.

(3) Payment data including, but not limited to, type of payer and amount charged.

(4) Cost data including, but not limited to, actual expenses for labor, supplies, equipment, implants, anesthesia, overhead, and administration.

(5) Outcome data including, but not limited to, expected level of rehabilitation, expected coverage timeframe, and incidence of infection.

(6) Access data including, but not limited to, date of injury, date of surgery recommendation, and data of procedure.

(7) Other data that is mutually agreed to by the Office of Statewide Health Planning and Development and the administrative director. The administrative director shall consult with the Office of Statewide Health Planning and Development to ensure that the data collected is comprehensive and relevant to the development of a fee schedule.

(c) The outpatient surgery facility fee schedule shall reflect input from workers' compensation insurance carriers, businesses, organized labor, providers of outpatient surgical services, and patients receiving outpatient surgical services.

SEC. 75. Section 5310 of the Labor Code is amended to read:

5310. The appeals board may appoint one or more workers' compensation administrative law judges in any proceeding, as it may deem necessary or advisable, and may refer, remove to itself, or transfer to a workers' compensation administrative law judge the proceedings on any claim. The administrative director, after consideration of the recommendation of the court administrator, may appoint workers' compensation administrative law judges. Any workers' compensation administrative law judge appointed by the administrative director has the powers, jurisdiction, and authority granted by law, by the order of appointment, and by the rules of the appeals board.

SEC. 76. Section 5311.5 of the Labor Code is amended to read:

5311.5. The administrative director or the court administrator shall require all workers' compensation administrative law judges to participate in continuing education to further their abilities as workers' compensation administrative law judges, including courses in ethics and conflict of interest. The director may coordinate the requirements with those imposed upon attorneys by the State Bar in order that the requirements may be consistent.

SEC. 77. Section 5401 of the Labor Code is amended to read:

5401. (a) Within one working day of receiving notice or knowledge of injury under Section 5400 or 5402, which injury results in lost time beyond the employee's work shift at the time of injury or which results in medical treatment beyond first aid, the employer shall provide, personally or by first-class mail, a claim form and a notice of potential eligibility for benefits under this division to the injured employee, or in the case of death, to his or her dependents. As used in this subdivision, ''first aid'' means any one-time treatment, and any followup visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care.

This one-time treatment, and followup visit for the purpose of observation, is considered first aid even though provided by a physician or registered professional personnel. ‘‘Minor industrial injury’’ shall not include serious exposure to a hazardous substance as defined in subdivision (i) of Section 6302. The claim form shall request the injured employee’s name and address, social security number, the time and address where the injury occurred, and the nature of and part of the body affected by the injury. Claim forms shall be available at district offices of the Employment Development Department and the division. Claim forms may be made available to the employee from any other source.

(b) Insofar as practicable, the notice of potential eligibility for benefits required by this section and the claim form shall be a single document and shall instruct the injured employee to fully read the notice of potential eligibility. The form and content of the notice and claim form shall be prescribed by the administrative director after consultation with the Commission on Health and Safety and Workers’ Compensation. The notice shall be easily understandable and available in both English and Spanish. The content shall include, but not be limited to, the following:

(1) The procedure to be used to commence proceedings for the collection of compensation for the purposes of this chapter.

(2) A description of the different types of workers’ compensation benefits.

(3) What happens to the claim form after it is filed.

(4) From whom the employee can obtain medical care for the injury.

(5) The role and function of the primary treating physician.

(6) The rights of an employee to select and change the treating physician pursuant to subdivision (e) of Section 3550 and Section 4600.

(7) How to get medical care while the claim is pending.

(8) The protections against discrimination provided pursuant to Section 132a.

(9) The following written statements:

(A) You have a right to disagree with decisions affecting your claim.

(B) You can obtain free information from an information and assistance officer of the state Division of Workers’ Compensation, or you can hear recorded information and a list of local offices by calling [applicable information and assistance telephone number(s)].

(C) You can consult an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers’ compensation attorneys, call the State Bar of California at [telephone number of the State Bar of California’s legal specialization program, or its equivalent].

(c) The completed claim form shall be filed with the employer by the injured employee, or, in the case of death, by a dependent of the injured

employee, or by an agent of the employee or dependent. Except as provided in subdivision (d), a claim form is deemed filed when it is personally delivered to the employer or received by the employer by first-class or certified mail. A dated copy of the completed form shall be provided by the employer to the employer's insurer and to the employee, dependent, or agent who filed the claim form.

(d) The claim form shall be filed with the employer prior to the injured employee's entitlement to late payment supplements under subdivision (d) of Section 4650, or prior to the injured employee's request for a medical evaluation under Section 4060, 4061, or 4062. Filing of the claim form with the employer shall toll, for injuries occurring on or after January 1, 1994, the time limitations set forth in Sections 5405 and 5406 until the claim is denied by the employer or the injury becomes presumptively compensable pursuant to Section 5402. For purposes of this subdivision, a claim form is deemed filed when it is personally delivered to the employer or mailed to the employer by first-class or certified mail.

SEC. 78. Section 5405 of the Labor Code is amended to read:

5405. The period within which proceedings may be commenced for the collection of the benefits provided by Article 2 (commencing with Section 4600) or Article 3 (commencing with Section 4650), or both, of Chapter 2 of Part 2 is one year from any of the following:

(a) The date of injury.

(b) The expiration of any period covered by payment under Article 3 (commencing with Section 4650) of Chapter 2 of Part 2.

(c) The last date on which any benefits provided for in Article 2 (commencing with Section 4600) of Chapter 2 of Part 2 were furnished.

SEC. 79. Section 5500.3 of the Labor Code is amended to read:

5500.3. (a) The court administrator shall establish uniform district office procedures, uniform forms, and uniform time of court settings for all district offices of the appeals board. No district office of the appeals board or workers' compensation administration law judge shall require forms or procedures other than as established by the court administrator. The court administrator shall take reasonable steps to ensure enforcement of this section. A workers' compensation administrative law judge who violates this section may be subject to disciplinary proceedings.

(b) The appeals board shall establish uniform court procedures and uniform forms for all other proceedings of the appeals board. No district office of the appeals board or workers' compensation administrative law judge shall require forms or procedures other than as established by the appeals board.

SEC. 80. Section 5502 of the Labor Code is amended to read:

5502. (a) Except as provided in subdivisions (b) and (d), the hearing shall be held not less than 10 days, and not more than 60 days, after the date a declaration of readiness to proceed, on a form prescribed by the court administrator, is filed. If a claim form has been filed for an injury occurring on or after January 1, 1990, and before January 1, 1994, an application for adjudication shall accompany the declaration of readiness to proceed.

(b) The court administrator shall establish a priority calendar for issues requiring an expedited hearing and decision. A hearing shall be held and a determination as to the rights of the parties shall be made and filed within 30 days after the declaration of readiness to proceed is filed if the issues in dispute are any of the following:

(1) The employee's entitlement to medical treatment pursuant to Section 4600.

(2) The employee's entitlement to, or the amount of, temporary disability indemnity payments.

(3) The employee's entitlement to vocational rehabilitation services, or the termination of an employer's liability to provide these services to an employee.

(4) The employee's entitlement to compensation from one or more responsible employers when two or more employers dispute liability as among themselves.

(5) Any other issues requiring an expedited hearing and determination as prescribed in rules and regulations of the administrative director.

(c) The court administrator shall establish a priority conference calendar for cases in which the employee is represented by an attorney and the issues in dispute are employment or injury arising out of employment or in the course of employment. The conference shall be conducted by a workers' compensation administrative law judge within 30 days after the declaration of readiness to proceed. If the dispute cannot be resolved at the conference, a trial shall be set as expeditiously as possible, unless good cause is shown why discovery is not complete, in which case status conferences shall be held at regular intervals. The case shall be set for trial when discovery is complete, or when the workers' compensation administrative law judge determines that the parties have had sufficient time in which to complete reasonable discovery. A determination as to the rights of the parties shall be made and filed within 30 days after the conference.

(d) The court administrator shall report quarterly to the Governor and to the Legislature concerning the frequency and types of issues which are not heard and decided within the period prescribed in this section and the reasons therefor.

(e) (1) In all cases, a mandatory settlement conference shall be conducted not less than 10 days, and not more than 30 days, after the filing of a declaration of readiness to proceed. If the dispute is not resolved, the regular hearing shall be held within 75 days after the declaration of readiness to proceed is filed.

(2) The settlement conference shall be conducted by a workers' compensation administrative law judge or by a referee who is eligible to be a workers' compensation administrative law judge or eligible to be an arbitrator under Section 5270.5. At the mandatory settlement conference, the referee or workers' compensation administrative law judge shall have the authority to resolve the dispute, including the authority to approve a compromise and release or issue a stipulated finding and award, and if the dispute cannot be resolved, to frame the issues and stipulations for trial. The appeals board shall adopt any regulations needed to implement this subdivision. The presiding workers' compensation administrative law judge shall supervise settlement conference referees in the performance of their judicial functions under this subdivision.

(3) If the claim is not resolved at the mandatory settlement conference, the parties shall file a pretrial conference statement noting the specific issues in dispute, each party's proposed permanent disability rating, and listing the exhibits, and disclosing witnesses. Discovery shall close on the date of the mandatory settlement conference. Evidence not disclosed or obtained thereafter shall not be admissible unless the proponent of the evidence can demonstrate that it was not available or could not have been discovered by the exercise of due diligence prior to the settlement conference.

(f) In cases involving the Director of the Department of Industrial Relations in his or her capacity as administrator of the Uninsured Employers Fund, this section shall not apply unless proof of service, as specified in paragraph (1) of subdivision (d) of Section 3716 has been filed with the appeals board and provided to the Director of Industrial Relations, valid jurisdiction has been established over the employer, and the fund has been joined.

(g) Except as provided in subdivision (a) and in Section 4065, the provisions of this section shall apply irrespective of the date of injury.

SEC. 81. Section 5814 of the Labor Code is amended to read:

5814. When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the full amount of the order, decision, or award shall be increased by 10 percent. Multiple increases shall not be awarded for repeated delays in making a series of payments due for the same type or specie of benefit unless there has been a legally significant event between the

delay and the subsequent delay in payments of the same type or specie of benefits. The question of delay and the reasonableness of the cause therefor shall be determined by the appeals board in accordance with the facts. This delay or refusal shall constitute good cause under Section 5803 to rescind, alter, or amend the order, decision, or award for the purpose of making the increase provided for herein.

SEC. 82. Section 5814.5 of the Labor Code is amended to read:

5814.5. When the payment of compensation has been unreasonably delayed or refused subsequent to the issuance of an award by an employer that has secured the payment of compensation pursuant to Section 3700, the appeals board shall, in addition to increasing the order, decision, or award pursuant to Section 5814, award reasonable attorneys' fees incurred in enforcing the payment of compensation awarded.

SEC. 83. Section 6354.5 of the Labor Code is amended to read:

6354.5. (a) Any insurer desiring to write workers' compensation insurance shall maintain or provide occupational safety and health loss control consultation services. The insurer may employ qualified personnel to provide these services or provide the services through another entity.

(b) The program of an insurer for furnishing loss control consultation services shall be adequate to meet minimum standards prescribed by this section. Required loss control consultation services shall be adequate to identify the hazards exposing the insured to, or causing the insured, significant workers' compensation losses, and to advise the insured of steps needed to mitigate the identified workers' compensation losses or exposures. The program of an insurer for furnishing loss control consultation services shall provide all of the following:

(1) A workplace survey, including discussions with management and, where appropriate, nonmanagement personnel with permission of the employer.

(2) A review of injury records with appropriate personnel.

(3) The development of a plan to improve the employer's health and safety loss control experience, which shall include, where appropriate, modifications to the employer's injury and illness prevention program established pursuant to Section 6401.7. At the time that an insurance policy is issued and annually thereafter, and again when notified by Cal-OSHA that an insured employer has been identified as a targeted employer pursuant to Section 6314.1, the insurer shall provide each insured employer with a written description of the consultation services together with a notice that the services are available at no additional charge to the employer. These notices to the employer shall appear in at least 10-point bold type.

(c) The insurer shall not charge any fee in addition to the insurance premium for safety and health loss control consultation services.

(d) Nothing in this section shall be construed to require insurers to provide loss control services to places of employment that do not pose significant preventable hazards to workers.

(e) The director shall establish an insurance loss control services coordinator position in the Department of Industrial Relations. The coordinator shall provide information to employers about the availability of loss control consultation services and respond to employers' questions and complaints about loss control consultation services provided by their insurer. The coordinator shall notify the insurer of every complaint concerning loss control consultation services. If the employer and the insurer are unable to agree on a mutually satisfactory solution to the complaint, the coordinator shall investigate the complaint. Whenever the coordinator determines that the loss control consultation services provided by the insurer are inadequate or inappropriate, he or she shall recommend to the employer and the insurer the actions required to bring the loss control program into compliance. If the employer and the insurer are unable to agree on a mutually satisfactory solution to the complaint, the coordinator shall forward his or her recommendations to the director. The cost of providing the coordinator services shall be paid out of the Workers' Occupational Safety and Health Education Fund created by subdivision (a) of Section 6354.7. However, no more than 20 percent of that fund may be expended for this purpose each year.

SEC. 84. Section 6354.7 is added to the Labor Code, to read:

6354.7. (a) The Workers' Occupational Safety and Health Education Fund is hereby created as a special account in the State Treasury. Proceeds of the fund may be expended, upon appropriation by the Legislature, by the Commission on Health and Safety and Workers' Compensation for the purpose of establishing and maintaining a worker occupational safety and health training and education program and insurance loss control services coordinator. The director shall levy and collect fees to fund these purposes from insurers subject to Section 6354.5. However, the fee assessed against any insurer shall not exceed the greater of one hundred dollars ($100) or 0.0286 percent of paid workers' compensation indemnity claims as reported for the previous calendar year to the designated rating organization for the analysis required under subdivision (b) of Section 11759.1 of the Insurance Code. All fees shall be deposited in the fund.

(b) The commission shall establish and maintain a worker safety and health training and education program. The purpose of the worker occupational safety and health training and education program shall be

to promote awareness of the need for prevention education programs, to develop and provide injury and illness prevention education programs for employees and their representatives, and to deliver those awareness and training programs through a network of providers throughout the state. The commission may conduct the program directly or by means of contracts or interagency agreements.

(c) The commission shall establish an employer and worker advisory board for the program. The advisory board shall guide the development of curricula, teaching methods, and specific course material about occupational safety and health, and shall assist in providing links to the target audience and broadening the partnerships with worker-based organizations, labor studies programs, and others that are able to reach the target audience.

(d) The program shall include the development and provision of a needed core curriculum addressing competencies for effective participation in workplace injury and illness prevention programs and on joint labor-management health and safety committees. The core curriculum shall include an overview of the requirements related to injury and illness prevention programs and hazard communication.

(e) The program shall include the development and provision of additional training programs for any or all of the following categories:

(1) Industries on the high hazard list.

(2) Hazards that result in significant worker injuries, illnesses, or compensation costs.

(3) Industries or trades where workers are experiencing numerous or significant injuries or illnesses.

(4) Occupational groups with special needs, such as those who do not speak English as their first language, workers with limited literacy, young workers, and other traditionally underserved industries or groups of workers. Priority shall be given to training workers who are able to train other workers and workers who have significant health and safety responsibilities, such as those workers serving on a health and safety committee or serving as designated safety representatives.

(f) The program shall operate one or more libraries and distribution systems of occupational safety and health training material, which shall include, but not be limited to, all material developed by the program pursuant to this section.

(g) The advisory board shall annually prepare a written report evaluating the use and impact of programs developed.

(h) The payment of administrative costs incurred by the commission in conducting the program shall be made from the Workers' Occupational Safety and Health Education Fund.

SEC. 85. The Director of Industrial Relations shall establish the following new positions for staffing of the workers' compensation courts:

(a) Eight workers' compensation administrative law judges.

(b) Eight hearing reporters.

(c) Eight senior typists (legal).

SEC. 86. It is the intent of the Legislature that all reimbursement expended by the Administrative Director of the Division of Workers' Compensation for the administration of the workers' compensation Return-to-Work Program established in Section 139.48 of the Labor Code shall be funded from the funds collected in the annual premium tax, collected under Section 12201 of the Revenue and Taxation Code, which is directly attributable to the compensation benefit rates and amounts set forth in the Revenue and Taxation Code.

SEC. 87. It is the intent of the Legislature that nothing in this act shall be interpreted to require any change in the administration, alternative dispute resolution component, or medical treatment component, of any program approved pursuant to Section 3201.5 of the Labor Code prior to January 1, 2003.

SEC. 88. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 89. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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